CAROLINA PAIN CENTER

Relieving Pain
Restoring Function

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby authorize _____ to release ALL medical information relating to my treatment and or/medical care to **Carolina Pain Center, P.C**. The information released shall be limited to the following time period(s) or illnesses:_____
_____
_____.

Carolina Pain Center, P.C. is hereby released from all legal liability that may arise from the release of the information requested. I understand that this information is to be disclosed for the purpose of medical care provided to me by **Carolina Pain Center, P.C.**

This authorization includes release of information for psychiatric/psychological illness, alcohol and/or drug abuse, drug-related conditions, alcoholism, HIV test results and/or diagnosis/treatment of AIDS or AIDS related conditions.

I understand that this consent is subject to revocation by me at any time and, unless an earlier date is specified, that it automatically expires one (1) year after the date below.

_____ _____
Signature of Patient or Authorized Party Date

_____ _____
Relationship to Patient Witness

PLEASE PRINT:

Patient Name: _____

Street Address: _____

City, State, Zip Code: _____

Date of Birth: _____

Patient phone: _____

Physician Fax: _____

PLEASE FAX RECORDS TO:

Carolina Pain Center, P.C.

252-222-3245 (facsimile)

Please call 252-222-3340 to make arrangements for transmittal of records NOT by facsimile.