



Centers for Pain Management, LLC  
1493 Kennedy Road, Suite B  
Tifton, Georgia 31794  
(229) 391-2910 Telephone  
(229) 386-4770 Fax

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Date of Birth:

\_\_\_\_\_  
Social Security Number

To: \_\_\_\_\_

The undersigned hereby authorizes and requests the release of the following information to:  
Centers for Pain Management

\_\_\_\_\_  
M.D.

Any information including diagnosis, medical history, examination reports, any treatments rendered, lab results, x-rays, mental health evaluations, hospital records and reports, surgical reports, prescriptions and any other protected health information.

Specifically

include: \_\_\_\_\_

**Initial in the space below:**

\_\_\_\_\_ I am aware that my records may contain information concerning AIDS /HIV and that this will be included in the information released.

**Purpose for Need of Disclosure**

\_\_\_\_\_ At the request of the individual

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of person giving consent  
(if not the patient please state relationship to patient)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Information Released by \_\_\_\_\_ Date Released \_\_\_\_/\_\_\_\_/\_\_\_\_

