Columbus Pain Center, P. C.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand this authorization is voluntary. I further understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ SSN: _____ Date of birth: _____

Persons / organization providing the information: _____

_____

Persons / organization receiving the information: **Columbus Pain Center, P. C., P. O. Drawer 9456, Columbus, Georgia 31908. Fax number is (706) 596-2115.**

The purpose of the use or disclosure is: **Evaluation and Treatment**

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that this authorization will expire on _____/_____/_____.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative: _____

Date: _____ Relationship to patient: _____

Columbus Pain Center
P. O. Drawer 9456
Columbus, Georgia 31908

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