Authorization to Release Medical Records

to Georgia Pain and Spine Care

I, _____, authorize the following person or organization,

_____

_____

to mail or fax my medical records to:

- Georgia Pain and Spine Care
  1665 Highway 34 East, Suite 100
  Newnan, Georgia 30265

  Phone: 770-252-7557 Fax: 770-252-7513

- Attention to: Jinialle – New Patient Coordinator
  Direct Contact #: 678-671-4674

I understand this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: **__N/A__**

Patient's Name: _____

SSN#: __xxx-xx-_____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____