

Authorization to Discuss or Disclose Health Information

I authorize Pain Solutions Treatment Center to discuss and/or disclose my health information with the following person/persons listed below:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that this information may 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: _____

Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____

Date: _____

Witness: _____ Date: _____

This form is valid for one year from patient signature date.

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