

PainSolutions

treatment centers

Authorization To Release Medical Records

I authorize _____
to mail or fax my medical records to:

PAIN SOLUTIONS TREATMENT CENTERS
400 Tower Rd., Suite 350
Marietta, Georgia 30060

Attn: _____

I understand that 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: _____

Print Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____

Date: _____ Patient's Acct #: _____

Witness: _____ Date: _____

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

Phone: (770) 590-1078 / Fax: (770) 422-7306
400 Tower Rd., Suite 350, Marietta, GA 30060
645 Molly Lane, Suite 110, Woodstock, GA 30189
15 Medical Drive, Suite 301, Cartersville, GA 30121