

# 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) 771-5620  
400 Tower Rd., Suite 350, Marietta, GA 30060  
645 Molly Lane, Suite 110, Woodstock, GA 30189  
15 Medical Drive, Suite 301, Cartersville, GA 30121  
148 Bill Carruth Pkwy., Suite 240, Hiram, GA 30141