



Authorization To Release Medical Records Information

I authorize Pain Solutions Treatment Centers to release my medical records to the following person or organization listed below:

Mail or Fax Records to:

Sending To: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Or Fax to Attn: _____

Fax Number: () _____
(All Faxes must be sent with HIPPA Fax Cover Sheet)

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