**Columbus Pain Center, P.C.**
**7141 Moon Road, Suite A**
**Columbus, GA 31909**

# Authorization for Release of Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand this authorization is voluntary. I further understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ SSN: _____-____-_____

Date of Birth: _____/_____/_____

Persons/Organization providing the information: _____

_____

Persons/Organization receiving the information: **Columbus Pain Center, P.C. 7141 Moon Road, Suite A, Columbus, Georgia 31909**

The purpose of the use or disclosure is: **Evaluation and Treatment**

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that this authorization will expire on: _____/_____/_____.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before the received the revocation.

Signature of patient or patient's representative: _____

Date: _____/_____/_____ Relationship to patient: _____

Phone: 706.322.7246
Fax: 706.596.2115