Regional Pain Care Center

AUTHORITY TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF THE INFORMATION CONTAINED IN MY MEDICAL RECORDS TO/FROM

(PLEASE INCLUDE PHONE NUMBERS AND FAXES TO THE OTHER DOCTOR'S FACILITIES YOU ARE REQUESTING)

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I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity, and release the provider, its agents and employees from any liability in connection with the release of information contained therein.

Printed Name DOB Signature Date

Phone Number Dr. Deborah Holubec Dr. Jerry Holubec Dr Wesley Merritt

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