Patient's Legal Name: _____

Birth Date: _____

I HEREBY AUTHORIZE Great River Pain Center TO SHARE:

- ☐ Any of my medical information, **including information about**:
- ☐ Mental health diagnoses and treatment*****
- ☐ Drug and alcohol use history and treatment*****
- ☐ My lab results ***(note: signing this form does NOT mean we will share result of STD or HIV/AIDS tests)***
- ☐ My appointment times, dates, and reasons for the visits
- ☐ The medications I am taking
- ☐ The following information (specify):

_____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to Great River Pain Center), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical/dental provider or my clinic to share my information with someone.

This authorization expires: ☐ When I cancel it in writing ☐ _____
If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

Signature: _____ Date: _____
*Relationship to minor patient (if parent or legal guardian)***:** _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)
Witness: _____ Date: _____

*******A minor patient's signature is **required** for us to share information about care for: (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above); (2) alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).*