AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Unifour Pain Treatment Center to release all information necessary to secure the payment for services I have received at the Center. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

I specifically authorize Unifour Pain Treatment Center to disclose information in my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records, to other physicians and healthcare providers to whom Unifour Pain Treatment Center may refer or consult with regarding my treatment. In addition, a copy of diagnostic test results ordered by my physician(s) may be forwarded to my primary and other treating healthcare providers.

I do hereby consent to authorize __________________________ (office use only) to disclose to Unifour Pain Treatment Center information from the records relating to my identity, diagnosis, prognosis, and/or treatment. I understand that the type of information to be disclosed may include my medical records, laboratory, and radiographic reports, and other:___________________________ (office use only) from the periods of 1980 to present.

The above mentioned is hereby released from all legal responsibility of Medical Records liability. The release of the information described above is from the patient's records, the extent indicated and authorized herein.

Patient's Date of Birth_____________________________

____ _________________________

Patient's Signature Date

____ _________________________

Patient's Legal Guardian or Authorized Representative Date

____ _________________________

Witness Date