Regional Pain Care Center

AUTHORITY TO RELEASE MEDICAL INFORMATION

I HEARBY AUTHORIZ THE RELEASE OF THE INFORMATION COTAINED IN MY MEDICAL RECORDS TO/FROM

(PLEASE INCLUDE PHONE NUMBERS AND FAXES TO THE OTHER'S DOCTOR'S FACILIITIES 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 INCLUDE, BUT NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR HUMAN IMMUNDODEFIECIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCEY SYNDROME (AIDS).

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

Printed Name Signature DOB Date

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