Spine & PainCare
Because surgery is not the first option! ®

2076 Woodruff Road, Greenville, SC 29607
120 Buford Ave, Anderson, SC 29621
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PHONE: 864-373PAIN (7246)
FAX: 864-286-3077
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PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

(Please Print, Illegible Request Will Delay Processing)

Name:_____
First Name Middle Initial Last Name

Social Security Number:_____ **DOB**:_____

SPINE AND PAIN CARE is authorized to: ☐ **SEND TO** ☐ **RECEIVE FROM**

1._____Fax # _____

2._____Fax # _____

3._____Fax # _____

4._____Fax # _____

☐ I give permission to release ALL of my medical records including information and records or copies of records to the history, diagnosis, treatment or service rendered to me in connection with any condition or disease.

☐ Release **ONLY** records specified below:

_____

_____

☐ **Do not** release records specified below:

_____

_____

Release Spine and Pain Care and the Recipient/Discloser listed above and any of their providers and staff from members from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Spine and Pain Care, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

THIS AUTHORIZATION EXPIRES ON : __/__/__ (optional) If no authorization date is given, this authorization shall remain in effect for a reasonable amount of time to compete the request.

_____ _____
Patient Signature or Responsible Party Date

_____ _____
Witness Signature Date