North Georgia Pain Clinic

PAIN MANAGEMENT SPECIALIST

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Pharmacy Release
Authorization for Release of Confidential Medical Information

Patient Information:

Patient Name:	
Date of Birth:	
SSN: *(last 4)*	
Daytime Phone:	

Pharmacy Information:

Pharmacy Name:	
Pharmacy Location:	
Phone:	
Fax:	

I authorized the release of my most recent office note and an ambulatory summary of care to the above listed pharmacy. This release is valid one year to date of signature. I may void this release at any time with written notification to the office.

Patient Signature:		Date:
Witness Signature:		Date: