



## Eastwind Pain Consultants

### RELEASE OF INFORMATION

In order to ensure patient confidentiality, it is the policy of this office to release information only to the patient. If you wish for others to receive ANY information regarding your care, you must sign this release. By signing this release, you are giving our office staff permission to release medical information to your referring physician, your insurance company, and any other treating physicians, therapists, or hospitals.

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine?

**YES**

**NO**

When calling our office regarding your care or to request prescription medication, please keep in mind that we need to speak to you directly. This will ensure that both parties receive the correct information.

I give my permission for Eastwind Pain Consultants to release my medical information to the following people (in addition to those listed above):

NAME

RELATIONSHIP TO PATIENT

_____	_____
_____	_____
_____	_____

**I UNDERSTAND THAT BY SIGNING THIS FORM I HAVE AUTHORIZED THIS OFFICE TO RELEASE MY MEDICAL INFORMATION.**

PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_