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Pain Management Clinic

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By signing this form, I _____, authorize the use and disclosure of my health information as described below:

1. You can disclose my health information as described below:
   - Leave message on the answering machine YES NO
   - Leave message with my spouse YES NO
   - Can fax information to my home YES NO
   - Can mail information to my home YES NO
   - Can e-mail information to me YES NO

2. You can leave a message confirming my appointment as described below:
   - Leave message on answering machine / voice mail / text message
   - Leave message with spouse

Name of person/persons authorized to discuss my medical information with:

1. _____ Phone#: _____

2. _____ hone#: _____

Patient Signature: _____

Date: _____