

  
**UNIFOUR PAIN  
TREATMENT CENTER**

*A Service of Frye Regional Medical Center*

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I **hereby** authorize Unifour Pain Treatment Center to release all information necessary to secure the payment for services I have received at the Center. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

I **specifically** authorize Unifour Pain Treatment Center to disclose information in my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records, to other physicians and healthcare providers to whom Unifour Pain Treatment Center may refer or consult with regarding my treatment. In addition, a copy of diagnostic test results ordered by my physician(s) may be forwarded to my primary and other treating healthcare providers.

I **do hereby** consent to authorize \_\_\_\_\_ (office use only) to disclose to Unifour Pain Treatment Center information from the records relating to my identity, diagnosis, prognosis, and/or treatment. I understand that the type of information to be disclosed may include my medical records, laboratory and radiographic reports, and other: \_\_\_\_\_ (office use only) from the periods of 1980 to present.

**The above** mentioned is hereby released from all legal responsibility of Medical Records liability. The release of the information described above is from the patient's records, the extent indicated and authorized herein.

Patient's Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Legal Guardian or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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