Johnston Pain Management, P.A.

250 Huff Drive, Jacksonville, NC 28546

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Patient Name), _____ (Date of Birth), _____ (Social Security Number),

authorize Johnston Pain Management to disclose information to the following people listed below. The following information may be given verbally or in writing.

Name: _____ Date of Birth _____

Social Security Number: _____

Relationship to Patient: _____

Name: _____ Date of Birth _____

Social Security Number: _____

Relationship to Patient: _____

- ☐ Appointment History
- ☐ General Medical Information
- ☐ Medical Billing & Insurance Information
- ☐ Psychological Information
- ☐ Treatment Plan
- ☐ Human Immunodeficiency Virus (HIV Status)
- ☐ Drug Screen Results
- ☐ Full Consent
- ☐ Other:

_____

_____

_____

I understand I may revoke this consent in writing at any time. This authority shall remain valid until written revocation is given.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____