

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: _____