COMMERCE Pain Management
Relieving Pain, Restoring Possibilities

Consent for Release

Patient Name	Date of Birth
	/ /

Form in which information/record is to be released

☐ Verbal	☐ Written	☐ Fax	☐ Email	☐ Other
☐ Photo	☐ CT Scan	☐ Video	Other:	

Reports to be released

☐ Medical Exam	☐ Written	☐ X-ray/CT/MRI	☐ Progress Notes	☐ Lab Results
☐ Discharge Summary	☐ CT Scan	☐ Video	Other:	

From: (Name / Address)	Please Send Information To:
Facility/Clinic Fax Number	**Commerce Pain Management** www.commercepain.com 413 Pottery Factory Drive, Commerce, GA 30529 Phone: 706-423-9449 Fax: 706-423-9443

I give Commerce Pain Management permission to share and receive any and all information about me with anyone and everyone who has treated, is treating, or will be treating me, including information about psychiatric conditions, sexually transmitted diseases including HIV and AIDS, substance abuse including drugs and/or alcohol, and criminal activity. Commerce Pain Management, may also share any and all information in my file with any and all local, state and/or federal authorities in the prevention of any illegal drug diversion. I understand by approving the release of information in the form of a fax, that confidentiality cannot be assured and I accept the risk that confidentiality may be breached when faxing information. I hereby release Commerce Pain Management Clinic and its employees from any and all liability that may arise from this release of information.

Signature of Patient:	Date:
Witness:	Date:
Relationship to Patient:	Date:

This authorization may be revoked at any time upon written notification by the signatory or patient but revocation has no effect on action previously taken

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