Authorization For Release Of Information

I, ______________________________, do hereby authorize __________________________ to release medical information relating to my treatment to Beresh Pain Management, Inc. The information released shall be limited to the following time period(s) or illnesses:

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Beresh Pain Management, Inc. is hereby released from all legal liability that may arise from the release of the information requested. I understand that this information is to be disclosed for the purpose of better care to me by Beresh Pain Management, Inc.

I understand that this consent is subject to revocation by me at any time and, unless an earlier date is specified, that it automatically expires one (1) year after the date below.

______________________________________ ______________________
Signature of Patient or Authorized Party Date

______________________________________ _________________________________
Relationship to Patient Witness

PLEASE PRINT:
Patient's Name: ______________________________
Street Address: _______________________________
City, State, Zip Code:___________________________
Date of Birth: _________________________________
Patient Phone: ________________________________
Physician Fax:________________________________