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I,____________________________, give the Center for Pain Management and Rehabilitation, S.C., permission to discuss my medical information with the following person(s):

- ___________________________________ Relationship____________________________
- ___________________________________ Relationship____________________________
- ___________________________________ Relationship____________________________

I authorize the release of medical information to the following facility or physician's office(s):

- ____
- ____
- ____

Patient Signature____________________________________ Date____________________________

Patient Name____________________________

Date of Birth_____________________________