



Midwest Joint Pain Institute, SC

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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 _____