**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**PATIENT NAME: ______________________________________________ DATE: _____________**

**DATE OF BIRTH: ______________________ SS#: ________________________________________**

I HEREBY AUTHORIZE AND REQUEST _____________________________________________

TO RELEASE THE REQUESTED INFORMATION TO:

Pain Specialist Corporation

**Ana Maria Platon, M.D.**

1506 Rock Quarry Road

Stockbridge, GA 30281

Ph: (770) 507-6995 Fax: (770) 507-8252

☐ ANY MRI , CT SCAN, X-RAY, DIAGNOSTIC TESTING, LAB RESULTS

☐ LAST 3 OFFICE NOTES ON PATIENT

☐ OTHER:___________________________________________________________________

Patient Signature: _____________________________________

Witness: _______________________________________________