AUTHORIZATION
TO DISCUSS, DISCLOSE OR SHARE HEALTH INFORMATION (HIE FORM)

I authorize Georgia Pain and Spine Care to discuss and/or disclose my health information with the following person(s) listed below:

1. Name: ____
   • Relationship to patient: __________________________________
2. Name: ____
   • Relationship to patient: __________________________________
3. Name: ____
   • Relationship to patient: __________________________________
4. Name: ____
   • Relationship to patient: __________________________________
5. Name: ____
   • Relationship to patient: __________________________________

I understand this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should **not** be released: ____________________________

Patient's Name: ____

SSN#: xxx-xx-______________ DOB: ________________________

Patient's Signature: __________________________________ Date: ______________

Witness: ____ Date: ______________

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