CENTRAL STATES
PAIN CLINIC℠
INNOVATIVE PERSONAL CARE

Limited Authorization and Release of Information Form

Patient Name:_____Date of Birth:_____Date:_____

How do you want to be addressed when summoned from the reception area?

☐ First name only ☐ Proper surname ☐ Other:_____

Please list any other parties who can have access to your health information:
(This includes step parent, grandparents, and any care takers who can have access to this patient's records.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please list any other doctors, medical clinics, and healthcare providers who can have access to your health information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Other contacts:

Spouse Name_____ Phone Number_____

Emergency Contact:

Name_____ Relationship _____

Phone Number _____

Signature:_____Date:_____