Release of Information

I ______________________________, give permission to Atlantic Pain Management to **discuss my healthcare** with the following persons. I understand that to remove anyone from this list I must do so in writing.

Name	Relationship	Telephone Number
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

I ____________________________, give permission to Atlantic Pain Management to **release my prescriptions to the following persons.** I will make them aware that anytime they come to pick up said prescriptions they are to bring photo ID that will be copied and they will need to sign for my prescriptions.

Names

____________________________ ____________________________

____________________________ ____________________________

____
Patient Signature and Date

____
Witness Signature and Date