

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

TO:

Practice/Physician Name _____

Address _____

Telephone _____ Fax _____

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Comprehensive Pain Management Institute / Gregory J. Bijak, M.D.

Address: 440 Greenfield Avenue, Suite D

City: Hanford State: CA Zip Code: 93230

This request and authorization applies to all of my medical records, specifically including those related to

- 1. Alcohol, Drug, and Substance Abuse diagnosis and treatment
- 2. Mental Health and Psychiatric diagnosis and treatment
- 3. HIV/AIDS diagnosis and treatment

This Release of Medical records does not expire. In the event that my patient-doctor relationship ceases to exist, I will provide your office with a letter terminating this authorization for any future release of information.

PLEASE FAX ALL RECORDS TO

Gregory J. Bijak, M.D.

559-746-0369

Prior to mailing them to the Mailing Address below:

Gregory J. Bijak MD, P O Box 8108, Visalia CA 93290-8108

Signature: _____

Date: _____

Witness: _____