**ZION PAIN MANAGEMENT CENTER**
**301 NORTH 200 EAST, SUITE 2A**
**ST GEORGE, UT 84770**
**PH# 435-688-7246 FAX# 435-688-1363**

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use/disclosure of my health information as described below. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name:_________________________ Date of Birth:__________________

### I authorize the release of my information from Zion Pain Management to:

☐ Physician________________________________
Address:________________________________
Phone:__________________________________
Fax:____________________________________

***PLEASE NOTE THE ABOVE INFORMATION MUST BE COMPLETE OR THERE WILL BE A DELAY IN YOUR RECORDS BEING SENT***

☐ Spouse __________________________________
☐ Other ___________________________________

### Information that may be used/disclosed: (Please check all that apply)

☐ Entire Medical Record
☐ Records of Visits (specify)___________________
☐ Other_____________________________________

### This authorization will expire:

☐ 1 Year from today's date
☐ Until further notified
☐ Other

________________________________ _______________
Signature of Patient or Representative Today's Date

_________________________________ _________________
Printed Name of Patient or Representative Relationship to Patient