

**ZION PAIN MANAGEMENT CENTER LLC
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/ to Zion Pain Management
 to/ from:**

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