

PAIN CARE CONSULTANTS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The Federal Government requires YOUR SIGNATURE to give us permission to release information to other parties at your request. Please list names below that our office is allowed to communicate with (including your spouse) and what information we may release.

Name: _____ Date of Birth: _____

Appointments – Yes or No

Your Account – Yes or No

Test Results – Yes or No

Name: _____ Date of Birth: _____

Appointments – Yes or No

Your Account – Yes or No

Test Results – Yes or No

Name: _____ Date of Birth: _____

Appointments – Yes or No

Your Account – Yes or No

Test Results – Yes or No

Name: _____ Date of Birth: _____

Appointments – Yes or No

Your Account – Yes or No

Test Results – Yes or No

Patient / Guardian Signature

Date

This release will expire Two (2) years of the above date.