INTEGRATIVE
PAIN MEDICINE CENTER

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ **Date of Birth:**_____

Previous Name:_____ **Social Security#:**_____

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

NAME: Integrative Pain Medicine Center / Michael Francis, MD

ADDRESS: 1570 Lindberg Drive, Suite 6

CITY: Slidell **STATE:** LA **ZIP CODE:** 70458

This request and authorization applies to:

☐ **Healthcare Information relating to the following treatment(s), condition(s) or date(s):**

_____

☐ **All Healthcare information**

☐ **Other :**_____

This Authorization is Effective Until:_____

Patient Signature: _____ **Date Signed:** _____