Oracle Pain Clinic, INC.

Patient Confidentiality

If you wish for others to receive information regarding your care, you must sign this release. By signing this you are giving the staff and subcontractors of Oracle Pain Clinic permission to release information to others such as insurance companies, any other necessary treating physicians, therapist, outpatient care, etc. if you would like us to release information to someone other than those mentioned above, please list their names/relationship to you and telephone number.

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Oracle Pain Clinic may need to leave messages on your machine with our name and number from time to time, and the reason that we are call (i.e. appointment reminders, etc.). Please circle whether or not it is ok for us to leave messages on your machine, in your voicemail or with whomever answers the phone.

Circle one: YES NO

I understand that by signing this form, I have authorized Oracle Pian Clinic and/or their staff or subcontractors to release my medical information.

Patient Name: (Please Print) _____

Patient Signature: _____

Date: _____/_____/_____