Comprehensive Pain Care, P.C.
Taylor Research, LLC
Donald R. Taylor, MD
833 Campbell Hill Street, Suite 112
Marietta, GA 30060
Telephone: 770-421-8080 Fax: 770-421-9566

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Services and Dates Requested: _____

_____

_____

I hereby authorize the following to release medical information, including any treatment related to drug and alcohol abuse, psychological/psychiatric/mental health conditions, or AIDS/HIV related conditions.

_____
(Facility/Physicians Name)

Telephone: _____
Fax: _____

<u>This information shall be released to:</u>
Comprehensive Pain Care, P.C.
Taylor Research, LLC
833 Campbell Hill Street, Suite 112, Marietta, GA 30060
Fax: 770-421-9566

Patient Signature: _____ Date: _____

Relationship to Patient (if patient unable to sign): _____

Patient's Telephone: _____