I give permission for Eastern Headache and Spine to:

___X_Release to _____Receive from

- ☐ East Carolina Pain and Spine- ECPC 2010 W Arlington Blvd Greenville NC 27834
- ☐ National Pain and Spine Center-2080 W Arlington Blvd Greenville Nc 27834
- ☐ Crystal Coast Pain 2111 Neuse Blvd New Bern NC 28562
- ☐ Johnston Pain Management-750 McCarthy Blvd New Bern NC 28562
- ☐ Eastern Physical Medicine -2245 Stantonsburg Rd Ste A Greenville NC 27834
- ☐ Kinston Regional Pain Center- 2100 Presbyterian Ln Kinston NC 27801

☐ Or other please list if other than who is listed:

Name of Office:
Address:
Phone or Fax

Patient Name:
DOB:
Phone:
Address:

I authorize Eastern Headache and Spine to release the above designated information contained in my medical record. I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to re-disclosure by the recipient.

www.EasternHeadacheandSpine.com
498-A Red Banks Road Greenville, NC 27858
Phone: 252-215-3067 **Fax**: 252-215-1045

As a professional provider: no cost is assessed for information released directly to another health care provider; all other releases are subject to reasonable costs for copying and distribution.

Patient or Authorized Representative Signature: ___________________________________
Date of Signature: ____