Interventional Pain Services

Consent to Release Confidential Information

Patient Name: _____ DOB: _____

Patient Address: _____

_____

I _____ hereby authorize and request, to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, to be send to:

Gregory Vassilev, M.D. Inc.
421 N. Rodeo Drive, Second Floor Suite #7
Beverly Hills, CA 90210
Please mail to above address or FAX to (424) 248-0203

Disclosure shall be limited to the following specific types of information:

_____

_____

Use of this information shall be limited to the following purpose(s):

_____

_____

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until: _____

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Signature _____ Date _____

GVMD Inc. fully complies with all HIPAA privacy regulations.