San Diego Pain Institute

Douglas Dobecki, M.D.

Personal Release of Information:

I, _____give my full permission to San Diego Pain Institute to disclose details of my billing records and discuss my treatment/care either verbally or in written form

with _____ _____
Name Relationship to patient

❑ Please check this box if you decline the above. In this case, information will only be released to you directly.

Patient Signature: _____ Date: _____/_____/_____

Print Patient Name: _____

Witness: Date: _____/_____/_____

If the patient is a minor or unable to sign, check one of the following:

❑ The patient is a minor: I/We sign consent to the foregoing.

❑ The patient is unable to sign because _____ and I/we sign the foregoing consent on his/her behalf.

_____ _____/_____/_____
Authorized Signature/Parent or Legal Guardian Date

_____

Printed Name of Parent or Legal Guardian. Authorized