SOUTHEAST REGIONAL
PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

Consent to Communication

Patient Name:_____ Date of Birth:_____Date:_____

Federal privacy regulations allow a health care provider, in certain limited circumstances, to discuss your health information, such as details about your care and treatment, with family members and close personal friends who are involved in your care. Depending on the circumstances, health care providers may be prevented from discussing your health information with someone who you might want them to. For that reason, some patients want to specifically authorize healthcare providers to engage in healthcare discussions with certain family members, friends, or other individuals.

This form allows you to designate family members, friends or others with whom Southeast Regional Pain Center can communicate about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to engage in discussion about your health care with the individual(s) listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individual(s) not listed on this form if such discussions are permitted by law.
- This form permits verbal communication only. This form does not allow the individuals listed below to obtain copies of your medical records.
- This form is entirely voluntary and optional. Refusing to sign this form will not impact your care provided at this practice.
- Changes to this form must be made in person at the practice listed above.

This form can be revoked by submitting an updated written request to Southeast Regional Pain Center. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you revoke it in writing or sign a new form.

Please list the individuals you wish designate to participate and communicate in your care with Southeast Regional Pain Center below.

Last Name, First Name	Relationship	Phone Number

Patient Printed Name:_____ Patient Date of Birth:_____

Patient/Legal Representative Signature:_____ Date:_____