A division of Eastern Carolina Anesthesia Associates, PLLC

General Consent

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Midtown Pain and Spine Clinic (a division of Eastern Carolina Anesthesia Associates):

- To file insurance claims for all services provided to me, and I authorize payment for those services to be made directly to the provider.
- To release any information about me to any referring physician or other provider or to any institution or provider as necessary to provide treatment or diagnosis for me.
- And my physician or their provider to release information about me as necessary to process claims for payment for services provided for me, including health and liability insurance companies, agencies processing Medicare, Medicaid, workers' compensation claims, medical benefits plans, case managers or reviewers or third parties responsible for paying claims for services provided to me.
- To release any information about me as necessary to submit authorization requests and appeals to my insurance or third party for the approval of (including but not limited to) office visits, procedures and medications.

This authorization expires ONE (1) YEAR after this date, except as disclosure is necessary after that date to process financial claims or is required or permitted by law. I understand that this authorization covers services I may receive today or within ONE (1) YEAR from today. I understand that I may revoke this authorization at any time by sending a written notification address to Midtown Pain and Spine Clinic, 8300 Health Park, Suite 309, Raleigh NC 27615. This revocation will be effective for future uses and disclosures of protected health information.

I release Midtown Pain and Spine Clinic, it's employees, officers, agents and physicians from any legal liability for disclosure authorized herein.

Patient Signature:_____ **Date:**_____