

CAROLINAS PAIN INSTITUTE, PA
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COMMUNICATIONS FORM

Chart Number: _____

In order that we may serve you more efficiently, please provide our office with the following information.

I _____ give permission for Carolinas Pain Institute to share my health information with the following people who are involved in my care.

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date

Print Name

Date of Birth