



I hereby authorize Hill Country Pain Associates to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purposes of identification and familiarization by the staff and the clinic physician(s).

Patient Signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date

I, _____ hereby authorize the release of my medical records to Hill Country Pain Associates.

Patient Signature

Date

Witness

Date