TRIANGLE
PAIN INSTITUTE

Communications Form

I, _____

Give my permission for Triangle Pain Institute to share my health information with

Following people who are involved in my care.

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

_____ _____

Patient Signature Date

_____ _____

Printed Name DOB