CT Integrated Pain Consultants
Zhaodi Gong, MD|PhD

RELEASE OF INFORMATION

I, _____ give my permission to Dr. Zhaodi Gong, director of **CT Integrative Pain Consultants, LLC**, to release information concerning this illness or injury to my insurance carriers responsible for payment. In addition, I authorize copies of all reports to be forwarded to my referring physician and the party or person listed below.

I also understand that it is my responsibility to request referrals from my primary care doctor in advance.

(name) _____

(relationship) _____

(phone number) _____

Patient Signature: _____

Date: _____

Witness: _____

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