DOUGLAS J. SPIEL, M.D.
INTERVENTIONAL PAIN PHYSICIAN
BOARD CERTIFIED RADIOLOGIST

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We have recently been advised of changes in guidelines/protocols of several pharmacies, in which, they are requesting additional information with regard to the medical condition, previous treatment and future treatment plan. In response to these changes, we may be required to give pharmacy information from you medical chart in order for you prescriptions to be filled.

The following is a statement that you authorize us to do so if requested by a pharmacy.

I, ____, give the office of Douglas Spiel, M.D. (including all staff members) permission to release any requested information with regard to my medical condition or treatment to the requesting pharmacy. I realize that this may be done verbally, in writing, or via copies of records.

I have been advised that this is optional, and if I do not agree to this, alternatives include going to a different pharmacy, different physician, or not filling prescriptions which require this information.

____
Patient Name (PRINT)

________________________________ ______________________
Patient Signature Date