

***PAIN THERAPY ASSOCIATES LIMITED***  
***455 South Roselle Road, suite 104***  
***Schaumburg, IL 60193***  
***847-352-5511***  
***847-352-5585 fax***

I agree to have my prescriptions faxed to any requesting pharmacy. I also agree to have any of my records faxed to requesting legal agencies or insurance companies, with the understanding that such faxed information may inadvertently be seen by a non designated party. Similarly, I also agree to allow my records to be copied and seen by any legal entity, insurance company, medical provider or medical entity that may be involved with my medical care.

I understand that Dr. Carey Dachman is a specialty physician and ***NOT PRIMARY CARE***. Any routine primary care-related tests, follow-up treatment or surveillance should be done by my primary care physician only.

\_\_\_\_\_  
Requested medication

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Print Legal Guardian Name