PAIN MEDICINE ASSOCIATES, INC.

Authorization to Release Medical Records

Date: _____

I _____hereby authorize Pain Medicine Associates, Inc. and/or its authorized representatives to release the following:_____

I request that this information be forwarded to:

{ } Myself { } Other

Name:_____

Address:_____

Phone: ( ) _____-_____

Patient Signature_____

Print Name:_____

Patient DOB:_____

Witness Signature:_____Date_____

Please Note: There is a charge of:
(This charge needs to be paid when or before records are released.)
Please make checks payable to Pain Medicine Associates, Inc.

[ ] $25 copy of medical records less than 5 pages

[ ] $50 more than 5 pages or extensive search

[ ] $100 One page Dictated report (additional pages $100 ea)