Pain Medicine Associates
your life, your health, pain free

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ______________________________

I ______________________________ hereby authorized Pain Medicine Associates, and or its authorized representative to release the following:

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I request that this information be forwarded to:

☐ Myself ☐ Other

Name: ______________________________

Address: ______________________________

Phone: ______________________________

Patient Signature: ______________________________

Print Patient Name: ______________________________

DOB: ______________________________

Witness: ______________________________ Date: ______________________________

(717) 340-7148 medicalrecords@painassociate.com