# RELEASE OF MEDICAL RECORDS REQUEST

To: Attention: Medical Records

Fax: Date:

Re: Request for Medical Records No. of pages (including cover sheet): 1

I hereby request and authorize you to release copies of all medical records concerning treatment including:

- Last three office notes
- Initial evaluation
- Medication log
- Radiology report

## Patient Information

Last Name First Name MI

Date of Birth SS #

## Delivery Instructions

Fax the records to the following SPINE AND PAIN CENTER provider at the number indicated below.

Provider Direct Fax

Contact Person Direct Phone

Please RUSH (patient is at our office) Send By 2nd Request

Comments

## Release Statement

I authorize SPINE AND PAIN CENTER to transmit and receive any records via fax or other electronic means

Patient Signature Date

The contents of this fax message and any attachments are intended solely for the addressee named in this message. This communication is intended to be and to remain confidential and may be subject to applicable attorney/client and/or work product privileges. If you are not the intended recipient of this message, or if this message has been addressed to you in error, please immediately alert the sender by fax and then destroy this message and its attachments. Do not deliver, distribute or copy this message and/or any attachments and if you are not the intended recipient, do not disclose the contents or take any action in reliance upon the information contained in this communication or any attachments.

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