



THE PAIN INSTITUTE®

Dedicated Exclusively to the Management of Acute and Chronic Pain

Medical Records Release

Name: _____

Address: _____

Birthdate: _____

I HEREBY AUTHORIZE AND/OR REQUEST OF

(Name of Doctor or Hospital)

(Address / Phone# / Fax#)

To release any and all medical records in my chart,
including history, notes, x-rays and tests to:

The Pain Institute
252 Whittington Parkway
Louisville, Kentucky 40222
502-423-7246
Fax: 502-426-7247

Patient Signature: _____

Date: _____

Patient email address: _____

