

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

Sign: _____

Date: _____

Witness: _____

Relation: _____