MISSION PAIN AND SPINE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name (Print): _____
(Last Name) (First Name)

Date of Birth: ___/___/___ Medical Record #: _____

I hereby authorize _____ to release copies of my medical records to: _____

MISSION PAIN AND SPINE
26932 OSO PARKWAY SUITE 275
MISSION VIEJO, CA 92691
(949) 916-8100 (949) 916-8555

☐ Medical Records ☐ Doctor's Notes ☐ Physical Therapy Reports

☐ Procedure Reports ☐ Lab Reports ☐ Films/CDs (X-Ray, MRI, CT)

☐ Radiology Reports (MRI's, CT Scans, X-Ray Reports, Dexa Scans, Bone Scans, Ultrasound Reports)

☐ Other: _____

Please allow 48 hours to process your request

☐ Call when ready and will pick up

☐ Mail Records to address shown above

☐ Fax Records to Fax # _____

_____ _____
Authorized Signature Date