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