TEMECULA PAIN MANAGEMENT

Medical Record Release Form

Patient Name: _____ Date of Birth: ____ / ____ / _____

SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( )_____ Email: _____

RECORDS REQUESTED FROM:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( )_____Fax: ( )_____ Email_____

SEND RECORDS TO:

Name: _____ SEND BY: [ ] Mail [ ] Fax [ ] Email

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( )_____Fax: ( )_____ Email_____

I, _____ (print name) hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information to the physician / person / facility / entity listed above.

_____ _____
Printed Name Date

_____ _____
Signature Date

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