Authorization to Release Medical Records

Patient Name:	
Date of Birth:	Social Security #:
Phone:	
Address:	
City, State, Zip:	

I, as named above, hereby authorize the following health professional/facility/laboratory/medical records service/pharmacy to release health information about me:

Individual/Facility:	
Address:	
City, State, Zip:	
Phone:	Fax:

Health Information being requested:

- ☐ Demographic Information
- ☐ Progress Notes / Operative Reports
- ☐ Imaging Reports (MRI, CT, X-Ray, etc.)
- ☐ Lab Reports
- ☐ Medical-Legal Information
- ☐ Other: ________________________________

Dates of service: From _______________ to _________________________

The following organization is authorized to receive my medical information:

Pain and Healing Institute
1964 Westwood Blvd. #435
Los Angeles, CA 90025
Ph: (310) 856-9488 | F: (310) 817-6402

Patient Signature:_______________________________________ Date: _____________________