MIDWEST PAIN & SPINE

Medical Record Authorization for Request/Release of Information

Patient's Name: _____ Date of Birth: _____/_____/_____
Please Print Patient Name

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

Home/Work/Mobile # _____ Home/Work/Mobile #_____
Circle one Area Code and Phone Number Circle one Area Code and Phone Number

Patient's Signature: _____ Date: _____

Medical Records Being Requested by:

☐ Entire Medical Record ☐ Most Recent Office Note ☐ Most Recent Procedure Note ☐ Xrays / MRI / CT

If requesting individual record, please add the dates requested: _____ to _____

Purpose of the requested is for: ☐ Patient/Representative Use, *or* ☐ Other (please specify) _____

Medical Records Requested by:

Records to be ☐ Faxed, if faxed #_____, or ☐ Mailed (check one)
Area Code and Phone Number

_____ Phone #_____
Name of Person/Organization (please print) Area Code and Phone Number

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

Send Medical Records by ☐ Mail ☐ Fax ☐ Picked Up in Office (Identification Required)

_____ Phone #_____
Name of Person to send records to (please print) Area Code and Phone Number

_____ Fax # _____
Organization to send records to (please print) Area Code and Phone Number

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

Return form via fax to 317-815-8951. Allow 10 business days for request to be processed and sent.

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www.midwestpain.net