MIDWEST PAIN & SPINE

Phillip R. Kingma, MD ● Allison L. Bauer, FNP-C

Medical Record Authorization for Request/Release of Information

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

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

Home/Work/Mobile # _____ Home/Work/Mobile #_____

Circle one Area Code and Phone Number Circle one Area Code and Phone Number

Medical Records Being Requested:

☐ Entire Medical Record ☐ Most Recent (Last 3) Office Notes ☐ Most Recent (Last 3) Procedure Notes

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

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

Medical Records Sent to:

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: _____

Medical Records Requested by:

_____Phone #_____

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

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

Patient's Signature: _____ Date: _____

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

MIDWEST PAIN INSTITUTE CENTER FOR MINIMALLY INVASIVE SPINE
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