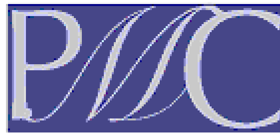

Pain Management Center of Naples, PA
3439 Pine Ridge Road Ste.301
Naples, Florida 34109
Phone: 239-593-9599 **Fax:** 239-593-4099

MEDICAL RECORDS RELEASE

Patient Name: ____ DOB: ____/_____/______
LAST FIRST MI MM DD YYYY

Phone: (_______) ______-_________ ▪ Cell ▪ Home ▪ Work SS #: ___________________

Address: ____
City State Zip

PLEASE RELEASE MY RECORDS **FROM:**

Name of Provider: ____________________________________ Phone: __________________

Address: ____ Fax: ____________________

____

To**:**____ Relationship to Patient: ________________

Phone: (_______) ______-_________ Fax: (_______)______-_________

Address: ____

____

▪ Complete Record

▪ Records of care from ______________________ to ________________________

▪ Records of care concerning the following condition(s): ________________________________

▪ Other. Specify: ____

I authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) above) or to otherwise release confidential information.

Signed: ____ Date: __________________________
(Patient or person legally authorized to consent on patient's behalf)