MEDICAL RECORDS RELEASE FORM

Patient
Name:_____DOB:_____

I understand that as part of my healthcare, Florida Spine & Pain Specialists originates and maintains health history symptoms, examination and test results, diagnosis, treatment, and may require medical records from previous physicians in order to plan for future care or treatments.

By signing this form I am giving permission to Florida Spine & Pain Specialists to obtain previous medical records from a physician or medical facility.

Physician/Group name: _____

Fax: _____

This request is for the following medical records:

_____

_____

_____	_____	_____
Signature of Patient or Legal Representative	Print Name	Date
_____	_____	_____
Witness Signature	Print Name	Date

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