RichmondSpine
INTERVENTIONS & PAIN CENTER

## Consent to Release Medical Records

Date: _____/_____/_____

Patient: _____ DOB: _____/_____/_____

I, _____, authorize Richmond Spine

Interventions and Pain Center to release my medical information to:

1. Physician/Facility _____

Phone: _____ Fax: _____

2. Physician/Facility _____

Phone: _____ Fax: _____

3. Physician/Facility _____

Phone: _____ Fax: _____

### Medical Records To Be Released

☐ Office/Procedure Notes ☐ Imaging Reports: _____ ☐ Lab Results

☐ Other: _____

_____

_____

Signature: _____ Date: _____

Printed Name: _____

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