Southwest Pain Management

REQUEST FOR RELEASE OF MEDICAL INFORMATION

MUST BE FILLED OUT COMPLETELY
PATIENT INFORMATION – PLEASE PRINT CLEARLY

Patient Name (printed): _____

Date of birth: _____

Social Security Number: _____

PHYSICIAN/FACILITY THAT IS TO **RELEASE** YOUR RECORDS:

Name: _____

Address: _____

City/State/Zip: _____

Fax Number: _____

PHYSICAL/FACILITY YOU WANT TO **RECEIVE** YOUR RECORDS:

Name: Southwest Pain Management

Address: 1350 W. Walnut Hill Lane Suite #100

City/State/Zip: Irving, TX 75038

Fax Number: 214-560-2555

****PLEASE NOTE. If requesting medical records to be released from SPM, we are only able to provide documentation that originates from our office. Hospital records, imaging reports from outside facilities, etc. will not be included and must be requested from those facilities directly.**

AUTHORIZATION FOR RECORDS RELEASE

I AUTHORIZE MY HEALTH CARE PROVIDER LISTED ABOVE TO RELEASE THE INFORMATION INDICATED BELOW TO THE PROVIDER NAMED ABOVE.

____ ALL OF MY RECORDS AT YOUR OFFICE OR FACILITY

_____ RECORDS FROM: _____ TO: _____

Patient signature: _____ Date: _____