Integrated Pain Solutions
FOR ACTIVE LIVING

Authorization to release Medical Records

To: ______________________________ Fax # : ____________________________
Patient: __________________________________ Date of Birth: _______________
Address: ____

I am requesting:
( ) All medical records
( ) Imaging report(s) only for date(s) of service: __________________________
( ) Operative report(s) only for date(s) of service: ________________________

Please provide the above requested information to :

Integrated Pain Solutions
1210 Gemini Place, Suite 300
Columbus, OH 43240
Phone: (614) 383-6450 Fax: (614) 383-6455

( ) I hereby authorize the release of the above requested medical information to the above listed recipient and understand if all medical records have been requested that all Integrated Pain Solutions records will be released: office notes, substance abuse history, disciplinary actions taken, etc.

( ) I understand I may revoke this consent prior to any action being taken.

( ) I understand that I may be charged a fee for this service.

____ ____________________
Patient signature/ Legal representative Date