Authorization to Release Medical Records

Provider will fill in at time requested

I hereby authorize _____ to release medical records and data pertaining to:

_____	_____
Patient Name:	Social Security/MRN:
_____	_____
Date of Birth:	Phone Number:
_____	_____
Street Address:	City, State, Zip Code

Please specify what records should be released:

- ❑ MRI
- ❑ X-rays
- ❑ Labs
- ❑ Toxicology (e.g. urine drug screen)
- ❑ Last 2 Clinic Notes
- ❑ Initial Consultation
- ❑ Other: _____

Fax Records to:

Center for Spine, Joint, and Neuromuscular Rehabilitation, P.C.
5651 Frist Blvd., Suite 712
Hermitage, TN 37076-3419
615-872-9966 Fax#: 615-872-9967

Patient/Guardian Signature: _____ Date: _____