PAIN SPINE & REHAB ASSOCIATES

501 North Frederick Avenue
Suite 302
Gaithersburg, MD 20877

Tel 301.591.8261
Fax 301.591.8262
www.painspineandrehab.com

PATIENT REQUEST FOR RELEASE OF MEDICAL INFORMATION

Date of Request _____

Patient Name_____Date of Birth_____

Facility ____Office ____ Hospital____Surgical Center ___Other Date of Service from _____ to _____

Information to be released to / from

Pain, Spine & Rehab Associates, LLC
501 N. Frederick Avenue – Suite 302
Gaithersburg, MD 20877
Phone (301) 591 – 8261 Fax (301) 591 - 8262

Information to be released to / from

Facility or Physician_____

Address_____

City_____State_____Zip_____

Phone (_____)_____ - _____ Fax (_____) _____ - _____

Information Requested:

_____ Entire Medical Chart

_____ H&P and/or Consultation note

_____ Progress Notes for the last _____ visits / months

_____ Discharge Summary

_____ Lab Results

_____ Imaging results _____(type)_____(area)

_____ Procedure Notes and/or Operative Summary s/p _____

_____ Pharmacy Log Other _____

We certify that the request for this information is from the patient or, in the case of a minor, the parent or guardian of the patient for the release of this information.

_____ _____
Signature of patient Signature of parent or guardian

_____ _____
Printed Name Printed Name

If no records are available, kindly check here ____ and fax back this form. Thank You.