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Global Pain Care
15610 Bear Valley Road, Ste A
Victorville, CA 92395
Tel: 760-245-9999
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RECORDS RELEASE FORM

DATE: ___«encDate»_

FROM WHOM:

Dr. Name_____

Dr. Phone #_____

Dr. Fax #_____

I hereby authorize you to release my medical information including the diagnosis and any treatment of examination rendered to me during the period of_____
To the following address:

GLOBAL PAIN CARE
15610 Outer Bear Valley Road, Ste A
Victorville, CA 92395
Ph: 760-245-9999
Fax: 760-245-8855

Please send the:

- Most recent MRI, CT Scan, X-Ray, Bone Scan reports
- Most recent Lab reports
- Past six months pharmacy records
- Other:_____

_____

____«LastName», «FirstName»_____ _____«DOB»_____
Patient Name Date of Birth

_____
Signature of Patient