RICHMOND SPINE
Interventions & Pain Center
Specializing in Spinal Injection Techniques, Spinal Cord Stimulation & Kyphoplasty for Vertebral Compression Fractures

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Consent to Release Medical Records

Date: _____

Patient Name:
_____

Address:
_____

I, _____, authorize Richmond Spine Interventions and Pain Center to release my medical information to:

1. Physician/Facility _____

Phone: _____ Fax: _____

2. Physician/Facility _____

Phone: _____ Fax: _____

3. Physician/Facility _____

Phone: _____ Fax: _____

Medical Records To Be Released

☐ Office/Procedure Notes ☐ Imaging Reports:
☐ Lab Results ☐ Other:

_____

_____

_____

Printed Name: _____ Date: ____/____/_____

Patient Signature: _____