Center for Spine Interventions

2713 Charles Hardy Parkway
Suite 222/224
Dallas, GA 30157
P-678-813-2741 F-770-575-3912

Date: _____

Patient Name: _____ DOB:_____

Requesting Medical Records from the following:

Facility Name: _____

Physician Name: _____

Address: _____

Telephone No: _____

Fax No.: _____

I _____ authorize my medical records be released to **Center for Spine Interventions**.

Please include the following:

(x) Complete Medication Profile and History

(x) Last 12 months of office notes and surgical notes

(x) Any imaging reports

(x) Drug Screen Results (if applies)

(x) Discharge Letter (if applies)

Patient Signature: _____Date: _____

Medical Assistant Requesting Records:_____