PAIN ASSOCIATES

Name: ______________________________________ DOB: ___________ Date: ___________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO OR FROM:

Dr. ____

Street: ____

City/State/Zip: ____

Fax/Email: ____

Please send a copy of my medical records to:

- ❑ The Person Stated Above.
- ❑ Fax: and or mail to:
- ❑ **Pain & Wellness of Scottsdale** 7337 E Thomas Rd, Scottsdale, AZ 85251,
- ❑ **Pain Associates of Gilbert** 610 N Gilbert Rd, Suite 309, Gilbert AZ 85234-4627
- ❑ ____

____________________________________ _____________

Patient Signature Date

LOCATIONS:
Pain & Wellness of Scottsdale 7337 E Thomas Rd, Scottsdale, AZ 85251, 480.360.4444
Pain Associates of Gilbert 610 N Gilbert Rd, Suite 309, Gilbert AZ 85234-4627, 480.926.1111