Integrated Pain Solutions

Patient Request for Records and Authorized Release

DATE OF REQUEST: _____

Patient Information:

Patient Name: _____

Date of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____

☐ **Send records to** ☐ **Request records from** (choose one)

Doctor / Medical Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Date(s) of Records: _____

Items Requested:

☐ X-ray report	☐ MRI report	☐ CT Scan report
☐ X-rays on CD (or film copy)	☐ MRI on CD	☐ CT Scan on CD
☐ Daily chart notes	☐ Other_____	

☐ **Send records to** ☐ **Request records from** (choose one)

Please select a clinic location:

☐ ANTIGO	☐ GREEN BAY	☐ MOSINEE
N2120 County Road S. Antigo, WI 54409	827 Cormier Road Green Bay, WI 54304-4706	880 South View Dr., Ste 15230 Mosinee, WI 54455
715-623-6500	920-569-2350	715-203-0471
Fax: 715-203-0704	Fax: 920-569-2333	Fax: 715-203-0704

By signing this form, I hereby authorize the release and transfer of my medical records and diagnostics, or copies of such.

PATIENT SIGNATURE: X_____ DATE: _____