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 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)

Integrated Pain Solutions (please select a location)

- ☐ 827 Cormier Road, Green Bay, WI 54304-4706
- ☐ N2120 County Road S, Antigo, WI 54409

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: _____

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