Advanced Pain Management Center

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

I request and authorize_____ to release healthcare information of the patient named above to:

Advanced Pain Management Center
(our main office)
9029 S. Pecos Road, Suite 2800
Henderson, NV 89074
Fax #702-739-8605

This request applies to all Diagnostic Testing, most recent medication and the last Physicians note. Please send or fax this information to the number above.

If you have any questions regarding this request of Medical Records, please call our office at ((702)739-8323.

Patient Signature: _____

Date: _____