Painlogics
Mobility. Simplified. Enhanced.

Medical Record Release Form

Patient Name _____ **DOB** _____

Patient Address _____

Patient Phone Number _____

Provider Designated to Disclose Records _____

Provider Address _____

Provider Phone Number _____

I authorize the release the of all my medical health records (including the diagnosis, records of treatment, Imaging and/or examination records rendered to me.) I request that these records be sent to:

Painlogics LLC
490 Sun Valley Dr. Suite 103
Roswell, GA 30076
Phone (678) 490-2255/ Fax (678) 799-7593

Patient Signature _____ Date _____

Patient Name _____