ORION
SPINE AND PAIN

Medical release of information form

I hereby authorize Orion's Spine and Pain, LLC to obtain the protected health information relating to the diagnosis, care, and treatment of:

Patients name:

_____

Date of birth:_____ Phone number:_____

_____ _____

Patient or authorized representative signature Date

Name of the Physician/Practice to request records from:_____

Address:

_____

Phone number:_____ Fax number:_____

For the medical practice:

Kindly fax the following documents at your earliest convenience:

1. All Imaging Reports: X-Rays, MRI's, CT's (relevant to pain we are to treat).
2. Last visit office note
3. EMG/Nerve Conduction Test Reports (if applicable)
4. Most recent labs including CBC, CMP/BMP, HbA1c (if not included in visit note)
5. List of pain procedures with dates (if applicable)
6. Discharge Letter (if patient was under pain management or receiving opioid medications)

Please send to:

Fax # 833-464-3390
Email: info@orionspineandpain.com
Phone #