

## 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 #

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