AUTHORIZATION FOR RELEASE OF RECORDS

DOCTOR or HOSPITIAL:____

PHONE:______________________ **ADDRESS:**____________________________________

CITY:________________________ **STATE:**____________ **ZIP:**____________________

I hereby authorize and request you release records to

Smart Pain Solutions LLC

11901 St. Charles Rock Road, Bridgeton MO 63044
p. 314.298.1400   f. 314.298.1400

_____X-RAYS
_____MRI
_____RADIOLOGY REPORTS
_____RECORDS
_____OTHER_____________

DATE:______________________ PRINT NAME:__________________________________

DATE OF BIRTH:______________ SSN:____

SIGNED:____
(Patient, legal Guardian or Representative)