**Authorization for Release of Medical Information**

Date: _____

To: _____

_____

_____

| Patient Name | Date of Birth | Social Security # |
|---|---|---|
| | | |
| | | |

This is to authorize and request that you furnish all medical or hospital information, including any radiology reports, concerning your examination, treatments, and care of the patient listed above.


**Southern Pain Specialists, P. C.**
7191 Cahaba Valley Road, Suite 204
Birmingham, Alabama 35242

**Attention: Medical Records**

(205) 995-9967
FAX: (205) 995-0635
(888) 436-4560

**WWW.SOUTHERNPAIN.COM**


Patient (or Guardian) Signature: _____