J. Edwin Dodd, M.D.

JPC JACKSON PAIN CENTER

1151 North State Street Suite 311-A
Jackson MS 39202
(601) 355-7246
Fax (601) 969-1173
www.jacksonpaincenter.net

Medical Records Authorization / Request

I hereby authorize ____

Phone: ____________________ Fax: ____________________ to release my

medical records to:

Jackson Pain Center
1151 North State Street Suite 311-A
Jackson MS 39202
Fax 601.969.1173

My name: ________________________ Signature: ________________________

My DOB: ________________________ My SS#: ________________________

My address: ____

Todays Date: ____________________

Upon completion of this form by patient, fax back to 601 969-1173