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Medical Records Release of Information Authorization

I hereby authorize Jackson Pain Center to release my medical records to the following entity (or entities):

Release to: _____

Mailing address: _____

OR Email address: _____

OR Fax number: _____

OR If you are picking up your own records, please say so: _____

My name: _____ Signature: _____

My DOB: _____ My SS#: _____

My address: _____

Today's Date: _____

This signed AND completed form can be returned by fax, email or mail