



J. Edwin Dodd, M.D.

JPC JACKSON
PAIN
CENTER

(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

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My name: _____ Signature: _____

My DOB: _____ My SS#: _____

My address: _____

Today's Date: _____

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