RECORDS RELEASE/REQUEST

TO: ______________________________

ADDRESS: ______________________________

CITY: ______________________________

STATE: ____________________ ZIP: ____________________

I HEREBY AUTHORIZE THE RELEASE OF MY ______________________________

____

OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

THE PAIN MANAGEMENT
CENTER OF TEXAS
DANIEL R. THEESFELD M.D.

3000 Alemeda Street
Fort Worth, Texas 76116
Phone: 817-560-2454
Fax: 817-560-2450

PATIENT NAME: ______________________________

DATE Of BIRTH: ______________________________

FROM: ______________________________

____

TO: ______________________________

____
Patient Signature