

# Coastal Pain Care PA

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## Medical Records Release

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_/\_\_\_/\_\_\_ Daytime phone Number (\_\_\_) \_\_\_\_\_

This is a request that my medical records be forwarded to Coastal Pain Care and that my medical health information may be shared with other healthcare providers or pharmacies to insure continuity of care.

(Please leave blank)

Records From:

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date