MEDICAL RELEASE FORM TO OBTAIN RECORDS

I authorize:
____
(Name of physician and or/facility)

____
PHONE FAX

To release my records to:

MidSouth Pain Treatment Center LLC
Michael E Steuer MD PC
MidSouth Interventional Pain Institute LLC

Michael E. Steuer, M.D. * Steven T. Richey, M.D. * Kirk L. Kinard, D.O.
Kristin M. Wilson, FNP-BC * Teresa S. Raby, CFNP * Katherine C. Smith, CFNP
Banjul L. Covington, CFNP * Teresa D. Smith, CFNP * Rebecca T. Robertson, CFNP *
Susan A. Gilbert, CFNP

122 Airways Place
Southaven, MS 38671
Phone: (662) 349-9990
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1365 West Brierbrook
Germantown, TN 38138
Phone: (901) 751-4112
Fax: (901) 751-5391

101 Rickey D Britt Sr Blvd, Ste 2
Oxford, MS 38655
Phone: (662) 236-5442
Fax: (662) 236-5295

Reason for disclosure: ____

RECORDS TO BE RELEASE:

____ Entire medical chart ____ MRI, CT scans X-rays

____ Lab reports ____ other______________________

PATIENT INFORMATION

PATIENT NAME: ____
(Please print)

PHONE: __________________________ **DOB:** _________________

SS#: __________________________________

ADDRESS: ____

Duration: I understand that this authorization is effective immediately and shall be valid for one year.
Right to Revoke: I understand that I may revoke this authorization in writing at anytime.
Re-use: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

Patient Signature: ____________________________ Date: ______________