Premier Chronic Pain Care
619 Boulevard NE
Atlanta, GA 30308
(p) 404.523.0111 (f) 844.663.3045

RECORDS RELEASE AUTHORIZATIONS

TO: _____
_____
_____
_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO :

Premier Chronic Pain Care
619 Boulevard NE
Atlanta, GA 30308

(p) 404.523.0111
(f) 844.663.3045
email: 619pcpcfax@gmail.com

All medical records in your possession, concerning my treatment. I release you from and all claims resulting of said records, as I realize they are a part of your permanent records.

DATE: _____

NAME: _____ D.O.B._____

SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____

WITNESS: _____