MEDICAL RECORDS RELEASE

I, _____ *[print patient name]*, hereby authorize **Rochester Pain Management LLC** to release my medical records to:

ROCHESTER PAIN SOLUTION

300 MERIDIAN CENTRE, SUITE 305

ROCHESTER, NY 14618

MAIN LINE: 585-491-6130 – FAX: 585-491-6131

Signed: _____ Date: _____
(Patient or Guardian)

_____
(Patient Date of Birth)

Witness: _____