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Date: _____

To: _____
Doctor/Physician

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the release of medical records relevant to treatment, or copies of such, and request that they be transferred to: **Lotus Spine and Pain**

- ☐ Last 2 Encounter Notes and Spinal Radiology
- ☐ _____
  _____

*If over 25 pages please mail*

_____
Print name of patient Date of Birth

_____
Signature (patient, parent or guardian)