St. George Spine and Pain Institute

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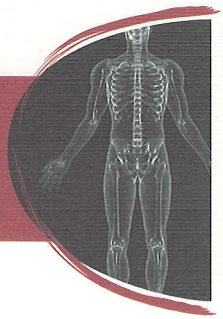

REQUEST FOR ACCESS TO MEDICAL RECORDS

DATE: _____

PATIENT NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____

DATE OF BIRTH: _____ PHONE: _____

I HERBY AUTHORIZE _____ TO PROVIDE MY MEDICAL RECORDS TO:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____

PHONE: _____ FAX: _____

DATE OF TREATMENT REQUESTED: (FROM): _____ (TO): _____

PURPOSE OF DISCLOSURE (CHECK ONE):

MEDICAL CARE ___ PERSONAL ___ INSURANCE ___ ATTORNEY ___ OTHER_____

MAIL RECORD: _____ PICK UP RECORD: _____ FAX RECORD: _____

I REQUEST THE ACCESS AS THE (CHECK ONE):

PATIENT ___ PARENT OF MINOR ___ GUARDIAN___ CONSERVATOR___

NAME (PRINT): _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____