Patient Information: I give permission to release	
Patient Name:Street Address:	Date of Birth: Last 4 numbers of SSN:
City, State, Zip:	
Email address:	
Release Information From:	Release Information To:
(Name of facility, person, company)	Pain Management Plus, PLLC
	249 Oak St_Forest City, NC 28043
(Street Address or PO Box, City, State, Zip Code)	Ph: 828-919-2393
(Phone number) (Fax number)	FAX RECORDS TO: 888-284-2932
PURPOSE OF RELEASE (check reason):	
✓ Continued patient care	
✓ Transfer of patient care	
Fill in dates of treatment for records to be release	acod.
Fill in dates of treatment for records to be released: ✓ ALL DATES	
Medical Office/Facility (check all that may appl	(v):
✓ Entire record	·11·
✓ Progress Notes, including mental health the	rapy notes
✓ Laboratory reports	• ,
✓ Radiology/X-Ray Reports	
	file from other providers and practices
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