COMPREHENSIVE PAIN MANAGEMENT CENTER

James T. Lin, MD- *Pain Specialist*
American Board Certified in Anesthesiology

MEDICAL RECORDS REQUEST FORM

I do hereby authorize

_____

Physician Name

_____

Address City/ State Zip Code

_____

Phone Number Fax Number Email

to release copies of my medical records to:

COMPREHENSIVE PAIN MANAGEMENT CENTER
558 St. Charles Drive, Suite 110
Thousand Oaks, CA 91360
Phone: (805) 557-7050 Fax: (805) 557-4992

RECORDS REQUESTED

- ❑ Progress Notes. Date range: _____
- ❑ Radiology reports. Description of requested report:_____
- ❑ EKG/ EMG/ EEG
- ❑ Labs
- ❑ Operative Reports
- ❑ Others:_____

_____

Patient Name Date of Birth

_____

Phone Number Email

_____

Signature Date