RECORDS RELEASE AUTHORIZATION

I Hereby Authorize:

Name:______________________________

Street Address:______________________________

City, State, Zip:______________________________

Phone:______________________________

Fax:______________________________

To release my medical records that are currently in his/her pos

☐ Eric J. Grigsby, MD, MBA ☐ David C . Miller MD

Napa Pain Institute
3434 Villa Lane, Suite 150
Napa, CA 94558
(707) 252-9660

Signature:______________________________

Print Name:______________________________

DOB:______________________________

Date:____________________ Witness:______________________________