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 possession.

☐ **Eric J. Grigsby, MD, MBA** ☐ **Konstantin Inozemtsev, MD**

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

Signature:____

Print Name:____

DOB:____________________

Date:______________ Witness:__________________________

Please list record type you are looking for: ______________________________________

Date range of records needed from: ____/____/____ to ____/_____/_____

Please specify how you would like to receive these records

Mail (if different from above):____
Fax (if different from above): ____
I will pick-up: Yes or No

Credit Card Number for Processing: _________________________ Exp___/____ Sec code: ________