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 to

☐ Eric J. Grigsby, MD, MBA ☐ Melanie D. Johansson, MD, FACEP

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

Signature:____

Print Name:______________________________________

DOB:____________________

Date:______________ Witness:________________________

Phone (707) 252-9660
Fax (707) 258-2780
www.NapaPainInstitute.com

Office Address
3434 Villa Lane, Suite 150
Napa, CA 94558

Mailing Address
P.O. Box 5510
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