MEDICAL RELEASE FORM TO OBTAIN RECORDS

I authorize:

_____

(Name of physician and or/facility)

_____

PHONE FAX

To release my records to:

MidSouth Pain Treatment Center LLC
Michael E Steuer MD PC
MidSouth Interventional Pain Institute LLC

Michael E. Steuer, M.D. * Steven T. Richey, M.D.
Christianne Curbow, FNP-C * Christy Egbert, FNP-BC * Holly Keel, FNP-C * Jennifer McDowell, ANP
Susan Smith, FNP-C * Teresa D. Smith, FNP-BC * Rebecca T. Robertson, FNP-BC
Jennifer Little, FNP * Ouida G. Wilkes, APRN, FNP-BC * Leanna King, FNP-C

122 Airways Place
Southaven, MS 38671
Phone: (662) 349-9990
Fax: (662) 349-2620

146 Timbercreek, Ste 200
Cordova, TN 38018
Phone: (901) 751-4112
Fax: (901) 751-9878

1365 W Brierbrook Rd
Germantown, TN 38138
Phone: (901) 531-8549
Fax: (901) 271-9099

101 Ricky D Britt Sr., Blvd, Ste 2
Oxford, MS 38655
Phone: (662) 236-5442
Fax: (662) 236-5295

2016 Greystone Square
Jackson, TN 38305
Phone: (731) 664-1773
Fax: (731) 664-1751

Reason for disclosure: _____

RECORDS TO BE RELEASED:

____ Entire medical chart ____ MRI, CT scans X-rays

____ Lab reports ____ other_____

PATIENT INFORMATION

PATIENT NAME: _____
(Please print)

PHONE: _____ **DOB:** _____

SS#: _____

ADDRESS: _____

Duration: I understand that this authorization is effective immediately and shall be valid for one year.
Right to Revoke: I understand that I may revoke this authorization in writing at anytime.
Re-use: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

Patient Signature: _____ **Date:** _____