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PATIENT REQUEST FOR TREATMENT RELEASE

DATE OF REQUEST:_____

PATIENT NAME:_____ DOB:_____

PATIENT ADDRESS:_____

_____

TELEPHONE:_____(Home)_____(Cell)

I would like to request release from pain management treatment from Athens Spine Center physicians. I understand that I will have to have a new referral if I wish to return under the care of Athens Spine Center physicians.

REASON:_____
_____
_____
_____
_____

I request a copy of my medical records forwarded to :

Physician Name:_____
Address:_____
_____
Telephone:_____(Office) _____(Fax)

_____ _____
Witness Date Signature of Patient Date

_____
Signature of Physician Date