

RELEASE OF MEDICAL RECORDS

I hereby request and authorize The Ainsworth Institute of Pain Management, Corey W Hunter, MD, to obtain Medical Information from:

Please mail, email or fax copies of these records to:

The Ainsworth Institute of Pain Management
115 East 57th Street, Suite 1210
New York NY 10022
info@ainpain.com
Fax number: (646) 607-9061

* If you should have any questions or require clarification, please feel free to contact the Ainsworth Institute of Pain Management at (212) 203-2813.

_____ Patient Name		_____ Date of Birth	_____ Social Security Number
_____ Address			
_____ City	_____ State	_____ Zip Code	

Print Name

Date

Signature of Patient

Signature of Guardian: