Innovative Medicine

Medical Records Release Related to Pain Assessment and Treatment
(To Dr. Turner)

To: _____
Custodian, Doctor, Clinic, or Hospital

_____
Address

Phone # _____ Fax #_____

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Charles Turner, MD
3554 Promenade Pkwy, Ste. H
Lafayette, IN 47909
Office 765-471-1100
Fax 765-471-1009

THE MEDICAL RECORDS AND HISTORY IN YOUR POSSESSION, CONCERNING MY HEALTH

Please release the following medical records:

Last 3 Progress Notes Initial Evaluation Labs from last year any pertinent imaging reports

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This information authorized for release may contain information that indicates that I have a communicable or venereal disease, which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, or the Human Immuno Defiency Syndrome (AIDS).

_____ _____
Print Name DOB

_____
Address

_____ _____
Patient Signature (If relative, state relationship) Date