"Put Your Pain To Rest"
LEMPER PAIN CENTERS

Brian A. Lemper, D.O.
Board Certified and Fellowship Trained in Pain Management

REQUEST FOR MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Patient Address: _____

City, State, Zip: _____

I, _____ hereby authorize on this date _____
Print Name Month/Day/Year
the release of my medical records to:

Office/doctor: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
All medical records will be forwarded to the address/fax listed above.

_____ _____
Patient Signature Date