**THE CENTER FOR SYMPTOM RELIEF, LLC**
**Request for Release**
**Of**
**Medical Records**

**To: _____**

_____

_____

**I herby authorize you to release medical records of:**

_____
**(Patient Name)**

_____
**(Date of Birth)**

**Please mail medical records to:**

**THE CENTER FOR SYMPTOM RELIEF, LLC**
**3600 OLENTANGY RIVER RD, SUITES C-3&C-3**
**COLUMBUS, OH 43214**
**PH: 614-459-0350 FAX: 614-459-0355**

**Information Needed:**
**__ All Records**
**__ Hospital Stay**
**__ Hospital Discharge Summary**
**__ Immunizations Only**
**__ Operative Report**
**__ Pathology Report**
**__ MRI / X-RAY**

**Patient Signature _____ Date: _____**