



## **Eastwind Pain Consultants**

### **Release of Medical Information**

I hereby authorize the release of any and all medical records pertaining to my  
care to:

**Eastwind Pain Consultants  
955 Eastwind Drive  
Westerville, Ohio 43081  
Phone: (614) 484-7246  
Fax: (614) 453-0789**

Patient Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_