

Release of Medical Information

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

Sarah E. Blake, MD
Capital City Pain Care
3600 Olentangy River Road
Building 480
Columbus, OH 43214

Fax: 614-298-8199
Phone: 614-442-0700

Patient Name: _____

Date of Birth: _____ Social Security No: _____

Signature: _____