JORG ROSLER, M.D.
851 South Rampart Blvd, Suite 100
Las Vegas, NV 89145
Phone: (702) 357-8004
Fax: (702) 357-8005

AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient Name:	**Date of Birth:**	Date:
Address:		City:
State:	Zip:	Phone Number: ( )

THIS IS TO AUTHORIZE:

Interventional Pain and Spine Institute
851 South Rampart Blvd, Suite 100
Las Vegas, NV 89145

TO REQUEST INFORMATION FROM:

Name of Doctor, Insurance Co., or Indicidual:		
Address:	**City:**	**State:**
Zip Code:	**Phone Number:**	**Fax Number:**

(CHECK RECORDS TO BE REQUESTED)

- ☐ All Medical Records
- ☐ Operative Reports
- ☐ NCV/EMG Reports
- ☐ Xray/MRI Reports
- ☐ Lab Work
- ☐ Office Notes
- ☐ OTHER

I realize that I am entitled to a copy of this Authorization.

_____ _____
Signature of patient or responsible party Date

Office personnel requesting:_____

PLEASE FAX TO : (702) 357-8005