

## RECORDS RELEASE/REQUEST

TO:

ADDRESS:

CITY:

STATE:

ZIP:

I HEREBY AUTHORIZE THE RELEASE OF MY \_\_\_\_\_

OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

THE PAIN MANAGEMENT  
CENTER OF TEXAS  
DANIEL R. THEESFELD M.D.

*3217 N. Fourth St.  
Longview, TX 75605  
Phone: 903-753-7333  
Fax: 903-753-4849*

PATIENT NAME:

DATE OF BIRTH:

FROM:

TO:

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