Center for Pain and Rehab Medicine

(CPARM) P.C.

D. Terrence Foster, M.D., M.A., FAAPMR

240 Medical Blvd.
Stockbridge, GA 30281

Tel: (678) 284-4000
Fax: (678) 284-6500

P.O. Box 824
Morrow, GA 30260

RELEASE OF MEDICAL RECORDS

PLEASE PRINT

Name _____ Date of Birth _____

S-S-N _____

I authorize the release of information pertinent to my case to any insurance company, adjuster, attorney, or healthcare professional involved in this case. I understand that a charge of $35.00 will be incurred for copies of medical record/documentation requested by me or a third party. I do hereby authorize the release of my medical records from Center for Pain and Rehab Medicine (CPARM), P. C. Please send a copy of my medical history and records in your possession to:

Name of Recipient Dr. D. Terrence Foster

Practice/Facility Center for Pain and Rehab Medicine

Address 240 Medical Blvd, Stockbridge, GA 30281

Fax: 678-284-6500
Phone 678-284-4000

Signature of Patient or Legal Guardian _____ Date _____

Witness Signature _____ Date _____

FOR OFFICE USE:

Payment: ❒ Cash _____ ❒ Check #_____ ❒ Credit Card _____ Exp. ____/____