InMotion
PAIN SOLUTIONS

Patient Request for Records and Authorized Release

Date of Request: _____

Patient Name: _____

Phone: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Please choose one:

- ☐ I would like my records sent from another provider to InMotion Pain Solutions.
- ☐ I would like my records sent from InMotion Pain Solutions to another provider.

Provider information:

Doctor/Medical Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Records: _____

Items Requested**:**

☐ X-ray report	☐ MRI report	☐ CT Scan report
☐ X-rays on CD (or film copy)	☐ MRI on CD	☐ CT Scan on CD
☐ Daily chart notes	☐ Other_____	

Request initiated at:

InMotion Pain Solutions
Attn: Medical Records
1967 51st Street NE
Cedar Rapids, IA 52402

Phone: 319-200-1495
Fax: 319-200-1185

By signing this form, I hereby authorize the release and transfer of my medical records and diagnostics, or copies of such.

Patient Signature: X_____ Date: _____

Benjamin C. Wyant, D.C.
InMotion Pain Solutions
319-200-1495 | InMotionPainSolutions.com
1967 51st Street NE, Cedar Rapids, IA 52402