PRECISION PAIN CENTER
INSURANCE • WORKERS' COMP • PERSONAL INJURY

Stuart Baird, MD
7380 W. Sahara Ave., Suite 160
Las Vegas, NV 89117
Office: 702-779-6800
Fax: 702-781-1700

AUTHORIZATION TO REQUEST MEDICAL RECORDS

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

THIS IS TO AUTHORIZE:

Precision Pain Center
7380 W. Sahara Ave., Suite 160
Las Vegas, NV 89117

TO REQUEST INFORMATION FROM:

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

(CIRCLE ALL 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 guarantor: _____ Date: _____