

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security No. _____

I HEREBY AUTHORIZE:

University Pain Clinic
4160 John R Ste. # 522
Detroit, MI 48201
Phone: 313.745.7246 Fax: 313.833.8477

TO DISCLOSE ANY INFORMATION CONTAINED IN MY MEDICAL RECORDS TO:

Physician/Individual: _____

Address: _____

Phone #: _____ FAX # _____

THE EXTENT OR NATURE OF THE INFORMATION TO BE DISCLOSED IS:

History & Physical treatment records, initial evaluation reports, progress notes, alcohol and drug abuse records, and surgery reports. This authorization also allows release of _____ psychological service records and social services records, if any.

Other tests, X-ray reports, special studies with any or all diagnostic tests: MRI, EKG, EEG, _____ NCS, EMG, Myelogram, CT Scans, Nerve Blocks, etc.

ALTHOUGH I MAY REVOKE THIS AUTHORIZATION AT ANY TIME (NOT RETRO-ACTIVELY) IT WILL EXPIRE IN 90 DAYS, OR ON THE DATE SET FORTH _____.

PATIENT/PARENT/LEGAL GUARDIAN

DATE

WITNESS

DATE