UNIVERSITY Pain Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

_____
Street Address

_____
City State Zip

Date of Birth: _____ Social Security No. _____

I hereby authorize:

University Pain Clinic Associates
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: _____

_____
Street Address

_____
City State Zip

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's Signature Date

_____ _____
Witness Signature Date