AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO UNIVERSITY PAIN CLINIC ASSOCIATES

Patient Name: ____

____
Street Address

____
City State Zip

Date of Birth: ____________________ Social Security No. ____________________________

I hereby authorize:

Physician/Individual: __________________________________

____
Street Address

____
City State Zip

Phone #: ________________________ FAX # ________________________________

To disclose any information contained in my medical records to:

University Pain Clinic Associates
Harper Hospital Professional Building
4160 John R Ste. #522
Detroit, MI 48201
Phone: 313-745-7246 Fax: 313-833-8477

Purpose: Pain Management - Evaluation and Treatment
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. It may also include 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 at the date set forth.

____ ________________________
Patient/Parent/Legal Guardian's Signature Date

____ ________________________
Witness Signature Date