AMERICAN PAIN & SPINE CENTER, PC
3845 Monroe St
Dearborn, MI 48124

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize ____to release
Name of Facility/Person

information from the record of:

___________________________________ __________________ ______________________**as described below to**
Patient Name **Birth Date** **SSN/MR#**

____ (_____)_________________ (_____)_______________
Name of Facility/Person **Phone** **Fax**

____
Facility/Person Address

Records are requested for the purpose of **(PROVIDE A DETAILED DESCRIPTION):**_________________________

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<u>Specific information to be released (check all that apply):</u>

☐ Consultation Reports	☐ Medical History & Physical Exam	☐ Physician Orders
☐ Discharge Summary	☐ Medication Administration Records	☐ Progress Notes
☐ Laboratory Report/Tests	☐ Operative Report	☐ Psychiatric/Psychological Evaluations
☐ Mammography Report	☐ Pathology Report	☐ Radiology Report
☐ Emergency Dept. Report	☐ EKG Report(s)	☐ Discharge Instructions

☐ Other, specify:____

HIV, Mental Health and Drug Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ **HIV** ☐ **Mental Health (Psychiatric)** ☐ **Drug & Alcohol**

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. I understand that I have the right to revoke this authorization at anytime by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: ____

____ ____________________
Signature of Patient or Legal Representative Date

____ ____________________
Printed Name of Patient or Legal Representative Witness