PAIN CONSULTANTS OF MICHIGAN, PLC

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient's Name _____
LAST FIRST MIDDLE DATE OF BIRTH

Address: _____ ( ) _____
STREET CITY STATE ZIP CODE TELEPHONE#

I, authorize _____, its director or designee to release information, specified below:

____ MY ENTIRE MEDICAL RECORDS:

____ MY MEDICAL RECORD FOR THE DATES: _____
_____

____ SPECIFIC DOCUMENTS: _____
_____

TO: _____

THE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE

____ Continued Medical Care ____ Legal Matter _____ Insurance Payment or Claim
____ Other:

I release Pain Consultants of Michigan, PLC (PCMI) from all responsibility or liability that may arise from the release of this information or these records. I authorize PCMI to release information contained in my patient records, including as applicable: Alcohol and drug abuse and mental health treatment information protected under the regulation in Title 42 of the Code of Federal Regulations Part II, information about communicable diseases and infections, as defined by Department of Public Health rules (Michigan Public Health Code) which includes venereal disease, tuberculosis, human immunodeficiency virus – HIV, acquired immunodeficiency syndrome – AIDS, and AIDS related complex – ARC.

This consent will expire one year after the date signed.

I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken by my authorization. Such revocation must be in writing and sent to Office Manager – Pain Consultants of Michigan, PLC. I understand that there is a potential for protected health information to be re-disclosed by the recipient.

X _____ _____
Signature of Patient Date Signed

X_____ _____ _____
If other than patient signing Relationship to Patient/Authority Date Signed

X _____
Signature of Witness