ANA PAIN MANAGEMENT, P.C.

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient name: _____

Date of Birth: _____

Social Security Number: _____

Information Release to:

ANA Pain Management
P.C. 15945 19 mile Road Ste 202
Clinton Township,
Michigan 48038

PH: 586-286-7426
Fax: 586-329-4751

From:

Information Release:

- ☐ **History/ Physical**
- ☐ **X-ray films**
- ☐ **Progress Notes**
- ☐ **Physical Therapy notes**
- ☐ **Lab/ X-ray/ MRI reports**
- ☐ **EKG reports**
- ☐ **Others**

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until three years from date of execution at which time this authorization expires.

Signature of Patient or Legal Representative : Date: