Michigan Advanced Pain & Spine

27101 Schoenherr Road, Suite 200
Warren, MI 48088
Phone: (586) 806-6466 Fax: (586) 806-6395

MEDICAL RECORDS RELEASE FORM

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____
DATE OF BIRTH: ___/___/___ SSN: ___-___-___ SEX: M / F PHONE: _____
ADDRESS: _____
CITY: _____STATE: _____ZIPCODE:_____

I, _____ herby authorize Michigan Advanced Pain & Spine , its director or agent to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. However, such notes may contain information on: general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.

1. Name or title of person or organization and address to whom information is to be:

Disclose To:	Requested From:
Michigan Advanced Pain & Spine	_____
27101 Schoenherrr Rd.	_____
Suite 200	_____
Warren, MI 48088	_____
P: (586) 806-6466	P: _____
F: (586) 806-6395	F: _____

2. The purpose or need for such disclosure
   _____At the request of the patient _____ Personal Use _____ Continuation of Care _____Attorney
   _____Workmen's Compensation _____Insurance _____Disability _____Other
3. Specific information to be disclosed/obtained as related to #2. Indicate date of service:
   _____ ER Memo _____ _____ Outpatient Visit _____
   _____ X-Ray/Lab _____ _____ Discharge Summary _____
   _____ Immunizations _____ _____ Diagnosis Dates _____
   _____ Other (Specify) _____
4. This authorization is valid only if received by Michigan Advanced Pain & Spine within 60 days of the date signed. This authorization expires when the patient information is disclosed as permitted in this authorization, or on authorization expires when the patient information is disclosed as permitted in this authorization, or on _____(date cannot exceed one year from the date of signature below).
5. I may revoke this authorization at any time. Revocations to this authorization must be present in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.
6. My care or treatment will not be conditioned on signing this authorization.
7. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
8. Michigan Advanced Pain & Spine and/ or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature: _____ Relationship: (if other than patient)_____
Patient, Legal Guardian, Personal Representative, Person under a POA*If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release.