Pain Clinic of Michigan

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Dr. Rakesh Vakhariya, D.O. * Dr. Jason Peter, D.O. * Dr. Mark Mounayer, M.D.

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

1. PATIENT INFORMATION

NAME:_____ SSN: _____

ADDRESS:_____

_____

_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

2. AUTHORIZATION FOR RELEASE: I hereby authorize:

_____

_____

_____

To release, disclose and deliver the medical information described below to:

AUTHORIZED RECIPIENT: Dr. Rakesh Vakhariya, D.O.
Dr. Jason Peter, D.O.
Dr. Mark Mounayer, M.D.
Pain Clinic of Michigan
5456 15 Mile Rd, Ste101
Sterling Heights, MI 48310
Phone: 586-977-7246 Fax: 586-977-1492

3. SPECIFIC AUTHORIZATION: I specifically authorize the release of ALL medical information relating to the above-named patient including, but not limited to, the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment; (2) mental health treatment; and (3) HIV-AIDS related information, if such information is contained in the records. Such medical information shall include but not limited to, the following: (1) history and physical treatment records, initial evaluation reports, progress notes, surgery reports, physiological service records and social service records; and (2) other tests, x-ray reports, special studies with any diagnostic tests: **MRI, EKG, EEG, NCS, EMG, Myelogram, CT Scans, Nerve Blocks and all other tests**. This authorization includes reports, correspondence, test results and any other information in the records, whether generated by authorized provider or other entity.

4. VALIDITY: I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure above. I agree that any release which has been made prior to the revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of the information as indicated above.

_____ _____

Signature of Patient Date