



AUTHORIZATION TO TRANSFER MEDICAL RECORDS

1. Patient Information:

NAME: _____

DATE OF BIRTH: _____

2. Authorization to Release: I hereby authorize:

Facility: _____

Fax Number: _____

Phone Number: _____

****URGENT****
Requested Records:

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

AUTHORIZED RECIPIENT: Dr. Rakesh Vakhariya, D.O.
Dr. Mark Mounayer, M.D.
Pain Clinic of Michigan
Fax: 586-977-1492 (Sterling Heights)
Fax: 248-289-6540 (Rochester Hills)

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