431 Swartz Ct. Suite 200
Ionia, MI 48846

Phone: 616-841-2615
Fax: 616-828-1752

Medical Records Release

**** Starred items are required for completion of your request

RELEASE MEDICAL RECORDS FROM:

____
*Doctor/Hospital

____
*Street Address

____
*City, State, Zip Code

____
*Phone Number Fax

RELEASE MEDICAL RECORDS TO:

____
*Name of Company/ Agency / Person

____
*Street Address

____
*City, State, Zip Code

____
*Phone Number Fax

PATIENT INFORMATION:

____
*Print Patient's Full Name

____
*Date of Birth (month/day/year)

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSES: **CONTINUED TREATMENT FOR PAIN MANAGEMENT OR FOR REFERRAL FROM ADVANCED PAIN SOLUTIONS TO A DIFFERENT PROVIDER/AGENCY.**

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

____ ___ ___________________________________

(Signature of Patient or Guardian) (Date)

*There may be a charge for the copying of all medical records.

OFFICE USE ONLY

Records being requested:

□ Medical Records □ MRI □ CT □ EMG

□ X-Ray □ Procedural Records □Other_____________________