Mark A. Ellis, M.D.
Board Certified Pain Management Specialist
Medical/Lab Director

Terrance L. Hughes, M.D.
Board Certified Pain Management Specialist
Board Certified Physical Medicine & Rehabilitation

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, _____, _____
(Patient's Name) (Date of Birth) (SSN)

hereby request Ellis Pain Center to obtain from _____
type(s) of information from my records (and any specific portion thereof):

_____ Emergency Room ____ Out-Patient ____ OOA Restricted From _____, 20____

_____ In-Patient Record of Hospitalization From _____, 20____ to _____, 20____

_____ Yes _____ No To include HIV and AIDS information

_____ In _____ No To include drug, alcohol, and/or psychiatric information

_____ Face Sheet/Final Diagnosis	**_____ Lab Reports**	**_____ Admission/Discharge Summary**
_____ History & Physical Exam	**_____ Pathology Report**	**_____ Operative Report**
_____ EKG	**_____ Imaging Reports**	**_____ Emergency Room Reports**

For purpose of _____
All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent.

_____ _____
(Signature of Patient) **Date**

_____ _____
(Signature of Patient or Authorized Representative, Where Applicable) **Date**

_____ _____
(Signature of Witness) **Date**