

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

MEDICAL RECORD RELEASE

I,	, the undersigned authorizes Ellis Pain Center to release:		
Please check one of the following: ☐ All Medical Information and/or documenta health, HIV, and drug/alcohol substance at Specific or Limited Information from states	ouse records	ay include mental	
I authorize and give consent for Ellis Pain Center to ha	ave my medical records mailed or faxed	to:	
NAME OF FACILITY:ADDRESS:			
PHONE #: (*preferred	d method)		
I understand this information is strictly confidential as understand that this authorization will remain in effect State and Federal Regulation and except to the extent may withdraw this consent at any time.	ct for 365 days. I understand that unless	otherwise limited by	
PATIENT SIGNATURE DATE	WITNESS	DATE	
PRINTED NAME	DATE OF BIRTH		
PATIENT ADDRESS			