GREAT LAKES PAIN MANAGEMENT
DR. EMAD MIKHAIL M.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated, between the following parties:

FROM: _____ **TO: Dr. Emad Mikhail**

Great Lakes Pain Management
_____ **Fax(440)951-2365**

PLEASE NOTE NEW FAX NUMBER
_____

I, authorize this release of information to either verify services rendered to process a claim for benefits, to provide continuity of my medical care or as specified herein:_____. I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be at any time be further disclosed without my specific written authorization. I understand, also, that except to the extent that action has been taken based on my authorization at any time by written notification to the parties involved.

It is my desire that only the information in my___inpatient record,___clinic record,___emergency record and/or,___ambulatory testing (please check the appropriate box) indicated below is to be released as a result of this authorization:

_X_ Face Sheet	**___ HIV Status**
_X_ History & Physical	**___ Pathology Reports**
___ Discharge Summary	**__X_ Physician Progress Notes**
_X_Consultation Reports	**___ Physician Orders**
_X_ Radiology Reports	**__X_ Therapy Reports**
___ Laboratory Reports	**___ Emergency Treatment**
_X_ Operative Reports	**__X_ Other/specify here: Medication List**

I am also making the following qualification: If the information specified above contains information related to treatment for drug and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be included with other information to be released in association with this authorization.

_____
(Date) **(Patient or Guardian Signature)**

_____
(Date Of Birth)