Dr. Ariel Majjhoo
1030 N. Monroe Street, Monroe, MI 48162
24430 Ford Rd., Dearborn Heights, MI 48127
Ph: 734-682-3309
Fax: 734-682-1488

Consent for Release of Confidential Information

Patient's Name_____

DOB:____/____/____

I authorize and hereby request that a copy of my medical records be released as follows:
Information to be released to:

NeuroInterventional Pain Management
1030 N. Monroe St., Monroe, MI 48162
Fax: 734-682-3309 Phone: 734-682-1488

Information to be released from:

_____
Name
_____
Address
_____
City State Zip
_____
Fax

- Release ALL records contained in my file pertaining to patient's pain complaint.

~ or ~

- Release the following specific records:

_____
_____
_____

The purpose of this request is for continued medical care

I understand that the information contained in my medical records may include records pertaining to diagnosis evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism and/or drug addiction. It may also contain information regarding test results for AIDS, HIV infection, antibodies to HIV, or infection with any other probable causative agents of AIDS.

_____
Signature of patient, parent, or legal guardian Date

_____
Witness Date