NorthStar Rehab + Pain Clinics

Medical Information Release Authorization

_____ _____

Patient's Name Social Security Number

_____ _____

Date of Birth Physician Name

I, _____, authorize NorthStar Rehab + Pain Clinics, PLLC, to Release/obtain information contained in the medical records of the patient identified above. I understand that these records are protected under federal regulations governing confidentiality and cannot be distributed without my written consent. I understand that I may revoke this consent at any time. I expressly waive any and all privileges that might otherwise attach to such records. Federal law prohibits the recipient of the above requested information from making any further disclosure except with the specific written consent of the person to whom it pertains.

Specific information to be disclosed:

Record/Date of Service:

- Bone Scan: Date: _____
- MRI Body Part: _____ Date: _____
- CT Scan Body Part: _____ Date: _____
- X-rays Body Part: _____ Date: _____
- Medical Records: Date: _____
- EMG/NCS Body Part: _____ Date: _____

_____ _____

Patient Signature Date

_____ _____

Witness Date