PAIN AND SPINE CARE
MASROOR AHMED, M.D.

<u>AUTHORIZATION FOR MEDICAL/ HOSPITAL RECORDS & REPORTS</u>

Patient Name: ____
Last First MI

Patient Social Security Number: _________/_________/_________

Date of Birth: _____/_____/______.

TO WHOM IT MAY CONCERN:

I, (patient) ___________________________________ authorize you to release any and all of my Medical/Hospital Records and Reports of the past and present to my current Doctor. This may include my History & Physical, X-Rays, MRI's, CT Scans, EKG's and Lab Results. This authorization extends to any other party (Insurance Companies, prior or present employers, etc.) who may have my Medical information. A photocopy is accepted with the same authority as the original.

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Patient Signature Date