## PAIN & SPINE CARE MASROOR AHMED, M.D.

## PATIENT PHOTO IDENTIFICATION

I hereby give permission to the staff of Pain & Spine Care Center to take my Photo ID and to maintain it in my Patient History. I understand that this Photo ID will not be used for any other purpose than as part of my Medical Records.	
Patient Signature	 Date
r auent Signature	Date
Employee Signature	Date