Dennis C. Ford, M.D.
American Board of Pain Medicine
American Board of Anti-Aging
American Board of Anesthesiology
American Board of Family Medicine

Sarah Ford, NP-C

Health Information Request

I, _____, authorize _____
(Please print patient's name) (Name of facility or physician)

to release my health information to **Ford Center for Anti-Aging and Pain Management.**

Please provide the following records:

___*Office visits* ___*Procedure notes* ___*Financial statements* ___*Mental health records*

___*Radiology reports (x-rays, MRI's, CT's, bone scan reports, ect.)* ___*Demographical Information*

___*UDS (including drug screen results)* ___*Other (specify)*_____

I am requesting this information for continuation of care. Please fax these records to the number below, or mail to the address below. Thank you.

_____ _____
Patient Signature Today's Date

_____ _____ _____
Witness signature and Date Patient SSN Patient DOB

NOTE: The PHI (Personal Health Information) is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the requesting party. It is only to aid in providing specific healthcare services to this patient. Thank you for your cooperation.