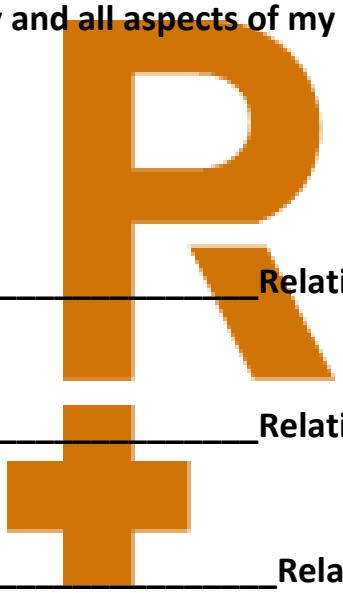
West Michigan Rehab & Pain Center

Ramin Rahimi D.O., FAAPMR

Authorization for Disclosure of Patient Information

I_____authorize West Michigan Rehab & Pain Center to discuss any and all aspects of my health with for following people



Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Signature of Patient:_____ Date:_____

Witness: _____ Date:_____