Authorization for Release of Medical Records and Personal Health Information

Instructions: Please complete, initial where appropriate, and sign this form, blanks or items not checked are assumed to be non-applicable or specifically not authorized for release. By signing this form, you are authorizing the release of medical records and personal healthcare information from/to another facility.

I hereby authorize release from: ❑ **FLORIDA PAIN PHYSICIANS**

❑ or ____

(Name of other releasing facility and fax number)

To disclose the information specified below from the health record of:

Name (Last): ______________________ (First): ______________________ (MI): _____

DOB: ______________ Social Security #: ______________________ Phone: ______________

This information is to be disclosed to: (Include Address)

❑ **FLORIDA PAIN PHYSICIANS**

❑ OR ____

____

For the purpose of: ❑ Continued Treatment ❑ Billing ❑ Personal ❑ Other: ______________

The following information is to be disclosed:

❑ Entire Medical Record
❑ Emergency Report
❑ Laboratory Reports
❑ Discharge Summary
❑ Rehabilitation Documentation
❑ History & Physical
❑ Billing Records
❑ Radiology Reports
❑ Operative Report
❑ X-ray (Imaging) Reports
❑ Consultation Reports
❑ Other: ______________

_____ (Initial) I understand that this may include information relating to HIV/AIDS, mental health, treatment and screening for alcohol or drug abuse, and/or sexually transmitted diseases.

Possibility of Re-disclosure: I understand that any information released may be subjected to re-disclosure and no longer protected by state and federal regulation.

Expiration and Revocation: I understand that this authorization is valid for 6 months from the date I sign it, or the duration of ______________________ (event). I have the right to revoke this authorization in writing at any time. The revocation will take place on the day it is received, except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

Condition of Treatment: I understand **FLORIDA PAIN PHYSICIANS** or agency cannot condition treatment upon signing this authorization.

____ ______________

Signature of Patient/Guardian/Legal Representative Date Signed

____ ______________________

Relationship to Patient Witness/Date

Intracoastal:
4796 Hodges Boulevard
Suite 101
Jacksonville, FL 32224

Northside:
2386 Dunn Avenue
Suite 111
Jacksonville, FL 32218

Orange Park:
859 Park Avenue
Suite 102
Orange Park, FL 32073

St. Augustine:
105 Whitehall Drive
Suite 115
St. Augustine, FL 32086

Phone: (904) 800-PAIN (7246) | **Fax:** (904) 719-7571 | **Website:** www.floridapainphysician.com