Prescription, Personal Information, and Billing Release Authorization

I, _____, give permission for the following person(s) to pick up prescriptions and or any of my personal health information, to include super sensitive information on my behalf. I understand that no prescriptions will be released other than to the person(s) listed below.

Please Note – Person(s) listed below will be required to present driver's license or other state/ federally issued photo ID when picking up prescriptions, billing information, and/or any personal health information.

1. Name: _____
   Relationship: _____
   Phone number: _____

2. Name: _____
   Relationship: _____
   Phone number: _____

3. Name: _____
   Relationship: _____
   Phone number: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Central Florida Pain Specialists where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

_____ (patient initials)

_____ _____

Name of signer Relationship to patient

_____ _____

Signature Date