AUTHORIZTION FOR RELEASE OF RECORDS

Patient Authorization for Use and Disclosure of Protected Health Information

Central Florida Pain Specialists takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Central Florida Pain Specialists to release your medical records to parties indicated. This Authorization will expire six months from the date signed.I hereby authorize Central Florida Pain Specialists to transfer, release or obtain information on:

Name of patient : _____

Date of Birth: _____

Social Security Number: _____-_____-_____

Obtain From:		**Send or Fax to:**	
_____		_____	
Physician / Institute		Physician / Institute	
_____		_____	
Address		Address	
_____		_____	
City, State, Zip		City, State, Zip	
_____	_____	_____	_____
Phone	Fax	Phone	Fax

Please Check Specific Information Requested

Date(s) of Treatment: All dates [ ] Or Specific Dates: _____ thru _____

[ ] All Medical Records

[ ] The most recent 2 years of pertinent information (Chart notes, labs, x-rays, and special test)

[ ] Specific information (please specify): _____

Purpose for which the disclosure is being made: (check one)

[ ] Attorney [ ] Insurance [ ] Doctor [ ] Personal

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 Florida Pain 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)

Relationship to patient: (check one)

_____ [ ] Self [ ] Legal Guardian [ ] Power of attorney

Print name of signer

_____ _____

Signature Date