**AUTHORIZATION FOR RELEASE OF RECORDS**

I hereby authorize Florida Pain Institute to transfer, release or obtain information on:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Name of Patient (print) Date of Birth Social Security Number

**\*\*\*\*\*\*\*\* This Authorization will expire six months from the date signed \*\*\*\*\*\*\*\***

OBTAIN FROM:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SEND OR FAX TO**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Physician/Institute Physician/Institute

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address Address

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City, State, Zip City, State, Zip

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Fax Phone Fax

Date(s) of Treatment: All dates: OR Specific Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ thru\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check Specific Information Requested

* 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 there will be a fee of $1.00 per page for the first 25 pages and then $0.25 a page there after plus applicable postage and handling when necessary for these records. This fee will be waived when records are to or from medical providers.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

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 TPRC, DBA Florida Pain Institute 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Signature

\*\*\* If representative is a court appointed legal guardian, a copy of court documents \*\*\*

\*\*\* must be provided and kept in medical records. \*\*\*