

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PERSONAL HEALTHCARE 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. After completion, please fax the form to 904-389-1082, and call 904-389-1010 with any questions.

**I HEREBY AUTHORIZE RELEASE FROM: [ ] RIVERSIDE PAIN PHYSICIANS AND RIVERSIDE SURGICAL CENTER**

or: \_\_\_\_\_  
**(NAME OF OTHER RELEASING FACILITY)**

**PHONE #(OF RELEASING PHYSICIAN/GROUP):** \_\_\_\_\_

**FAX# (OF RELEASING PHYSICIAN/GROUP):** \_\_\_\_\_

**TO DISCLOSE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORD OF:**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_ Primary Contact Phone # \_\_\_\_\_

**THIS INFORMATION IS TO BE DISCLOSED TO: (Include Address)**

[ ] RIVERSIDE PAIN PHYSICIANS AND RIVERSIDE SURGICAL CENTER, 7207 GOLDEN WINGS RD, JACKSONVILLE, FL 32244

or: \_\_\_\_\_

FOR THE PURPOSE OF:  Continued Treatment  Billing  Personal  Other: \_\_\_\_\_

**THE FOLLOWING INFORMATION IS TO BE DISCLOSED:**

- |  |   |
|--|---|
| <input type="checkbox"/> Entire Medical Record                           | <input type="checkbox"/> Rehabilitation Documentation |
| <input type="checkbox"/> Operative Report                                | <input type="checkbox"/> Emergency Report             |
| <input type="checkbox"/> History & Physical                              | <input type="checkbox"/> X-ray (Imaging) Reports      |
| <input type="checkbox"/> Laboratory Reports                              | <input type="checkbox"/> Billing Records              |
| <input type="checkbox"/> Consultation Reports                            | <input type="checkbox"/> Discharge Summary            |
| <input type="checkbox"/> Photographs, videotapes, X-rays or other images | <input type="checkbox"/> Other: _____                 |

\_\_\_\_\_ (Initial here) **I UNDERSTAND THAT THIS MAY INCLUDE** information relating to HIV/AIDS, mental health, treatment and screening for alcohol, drug abuse or other substance abuse, sexually transmitted diseases and gene related impairments (genetic testing).

**POSSIBILITY OF REDISCLOSURE:** 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. 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.

**NOT A CONDITION OF TREATMENT:** I understand the Riverside Pain Physicians/Surgical Center or agency cannot condition treatment upon my signing this authorization.

\_\_\_\_\_  
Signature of Patient/Guardian/Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness/Date

Auth Release of Records ver 8\_03\_2011.doc

**RIVERSIDE PERSONNEL ONLY:**  
Acknowledged by: (signature/date)

Processed:  Yes  No

Number of pages: \_\_\_\_\_