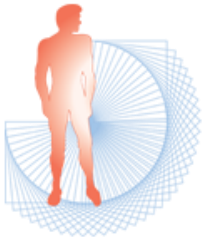

CENTRAL FLORIDA
PAIN MANAGEMENT
A Prospira PainCare Center of Excellence

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First Middle
Patient's Address: _____ City _____State _____ Zip _____
Home/Business Phone _____ Cell Phone: _____ E-Mail: _____

PERSON OR ENTITY TO RELEASE INFORMATION

☐Name: _____
Address: _____
Phone: _____
Fax: _____

PERSON OR ENTITY TO RECEIVE INFORMATION

☐ **Central Florida Pain Management**

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

____ Complete Medical Record ___Office Notes ___ Lab Reports
____ Procedure Reports ___ Surgery Records ___ Billing Records
_____ Other (Specify)

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance.
___ Workman's Compensation, ___ Other _____

This authorization will expire on _____. (If no date specified, this authorization shall expire 1 year after date signed.)

CHECK AND INITIAL BELOW:

___ I DO, ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto. *(Initials of individual giving authorization*) _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**. (*Initials of individual giving authorization)* _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment. *(Initials of individual giving authorization*) _____.

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and/or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date
(if applicable, attach document of guardianship or Power of Attorney)

(9/09)