**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

I authorize the release of my health information records to **Central Florida Pain Relief Centers**to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my healthinformation to:

**Central Florida Pain Relief Centers**

**683 Douglas Avenue Suite 101**

**Altamonte Springs, FL 32714**

**Office: 407.478.1510 Fax: 407.478.1512**

**(**List of all facilities, clinics, and offices from which information will be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician's Name Address Phone Number Fax Number

|  |
| --- |
| **1.** |
| **2.** |
| **3.** |
| **4.** |

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

Pharmacy Name Address Phone Number Fax Number

|  |
| --- |
| **1.** |
| **2.** |
| **3.** |
| **4.** |

HOSPITAL AND OTHER FACILITIES (for surgeries/procedures, MRI/CT SCANS and any LAB and X-RAY reports)

Facility Name Address Phone Number Fax Number

|  |
| --- |
| **1.** |
| **2.** |
| **3.** |
| **4.** |

Restrictions:

\_\_\_\_\_\_\_\_\_\_ There are NO restrictions on the information that can be released.

The following information CAN NOT be released:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DURATION**:**

This authorization shall be effective immediately. I understand this authorization to release medical records will become invalid when I am no longer a patient of Central Florida Pain Relief Centers. I understand I have the right to revoke this authorization, at any time by sending written notification to the privacy/compliance office at the above listed address.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

(PLEASE PRINT) Name of patient or personal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT) If personal representative, describe authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_