Interventional Rehabilitation of South Florida d/b/a
Interventional Pain Physicians of Miramar

Authorization for Release of Medical Information

Patient Name:______________________________ Date of Birth:__________________________

Address:____

Phone #:____________________ Social Security #:________________________________

I authorize ____

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to release any and all medical information relating to my treatment from__________ to__________ . This is to include all records, if any, concerning HIV or AIDS, mental or behavioral health or psychiatric care, and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care

Specific Items to be released:

___ Cardiovascular Reports ___ Emergency Room ___ Pathology Report

___ Consultation Report ___ History & Physical ___ Progress Note

___ Discharge Summary ___ Laboratory Results ___ X-Ray Reports

___ EKG Report ___ Operative Report

___ Photographs, videotapes or other digital images _X_ Records of prescription medications

___ Other (describe)____

Send information via ❑ Mail ❑ Fax to: *or* **❑ Hold for pick-up by authorized representative of:**

Dr. Lowell Davis / Dr. Rosemary Daly / Dr. Felix Ramirez
1951 S.W. 172nd Avenue Suite #314
Miramar, FL 33029
Telephone # (954) 447-5206

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Printed Name of Patient or Legal Guardian Relationship to Patient