Authorization for Release of Medical Information to Florida Pain Center

Patient Name: _____ Date of Birth: _____

Address: _____

Phone #: _____ Last 4 of Social: _____

I authorize (Name and Phone of medical facility holding your medical records):

_____

_____

_____

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 Reports
__Consultation Reports	__History & Physical	__Progress Note
__Discharge Summary	__Laboratory Results	__Xray Reports
__EKG reports	__Operative Reports	__MRI Reports

__Photographs, video, or other digital images X Records of prescription medications

Other (describe) _____

Send information via

__ Fax: 954-447-5259

__ Mail to 1951 SW 172 Avenue, Suite 314, Miramar, FL 33029

__Hold for pick up by authorized representative of _____

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.

Signed:_____ Date: _____

Printed Name:_____ Relation to patient:_____