AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Florida Pain Institute to transfer, release or obtain information on:

_____ _____ _____-_____-_____

Name of Patient (print) Date of Birth Social Security Number

********** This Authorization will expire six months from the date signed **********

OBTAIN FROM:_____

Physician/Institute

_____

Address

_____

City, State, Zip

_____

Phone Fax

SEND OR FAX TO:_____

Physician/Institute

_____

Address

_____

City, State, Zip

_____

Phone Fax

Date(s) of Treatment: All dates: OR Specific Dates: _____ thru_____

Please Check Specific Information Requested

- ☐ All Medical Records
- ☐ The most recent 2 years of pertinent information (Chart notes, labs, x-rays, and special test)
- ☐ Specific information (please specify): _____

Purpose for which the disclosure is being made: (check one) Attorney Insurance Doctor Personal

I understand that there will be a fee of $1.00 per page for the first 25 pages and then $0.25 a page there after plus applicable postage and handling when necessary for these records. This fee will be waived when records are to or from medical providers.
I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to TPRC, DBA Florida Pain Institute where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. _____ (patient initials)

Relationship to patient: (check one)

☐ Self ☐ Legal Guardian ☐ Power of attorney

_____

Print Name of Signer

_____

Signature

_____

Date

*** If representative is a court appointed legal guardian, a copy of court documents ***
*** must be provided and kept in medical records. ***

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5545 N. Wickham Rd. Suite 104 Melbourne, FL 32940 Phone: 321-784-8211 Fax: 321-775-0535

490 Centre Lake Drive NE Suite 200B Palm Bay, FL 32907 Phone: 784-8211 Fax: 321-265-5120

7455 S. US Highway 1 Titusville, FL 32780 Phone: 784-8211 Fax: 321-394-9425

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