595 N Courtenay Parkway
Suite 101
Merritt Island, FL 32953

FLORIDA PAIN
THE PAIN RELIEF EXPERTS

5545 N Wickham Road
Suite 104
Melbourne, FL 32940

Phone (321)784-8211 Fax (321)394-9425

AUTHORIZTION FOR RELEASE OF RECORDS

I hereby authorize Florida Pain (The Pain Institute, Inc) 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

There may be a charge for your records. If you pick records up for personal use there is a fee of $1.00 per page for the first 25 pages and then $0.25 a page there after.

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 Florida Pain 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