RIVERSIDE
PAIN PHYSICIANS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PERSONAL HEALTHCARE INFORMATION

Instructions: Please complete, initial where appropriate and sign this form, blanks or items not checked are assumed to be non-applicable or specifically not authorized for release. By signing this form, you are authorizing the release of medical records and personal healthcare information from/to another facility. After completion, please fax the form to 904-389-1082, and call 904-389-1010 with any questions.

I HEREBY AUTHORIZE RELEASE FROM: [ ] RIVERSIDE PAIN PHYSICIANS AND RIVERSIDE SURGICAL CENTER

or:_____

(NAME OF OTHER RELEASING FACILITY)

PHONE #(OF RELEASING PHYSICIAN/GROUP): _____

FAX# (OF RELEASING PHYSICIAN/GROUP): _____

TO DISCLOSE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORD OF:

Name: Last _____ First _____ MI _____

Birth Date: _____ Social Security # _____ Primary Contact Phone # _____

THIS INFORMATION IS TO BE DISCLOSED TO: (Include Address)

[ ] RIVERSIDE PAIN PHYSICIANS AND RIVERSIDE SURGICAL CENTER, 7207 GOLDEN WINGS RD, JACKSONVILLE, FL 32244

or: _____

FOR THE PURPOSE OF: ❑ Continued Treatment ❑ Billing ❑ Personal ❑ Other: _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:

❑ Entire Medical Record
❑ Operative Report
❑ History & Physical
❑ Laboratory Reports
❑ Consultation Reports
❑ Photographs, videotapes, X-rays or other images
❑ Rehabilitation Documentation
❑ Emergency Report
❑ X-ray (Imaging) Reports
❑ Billing Records
❑ Discharge Summary
❑ Other: _____

_____ (Initial here) **I UNDERSTAND THAT THIS MAY INCLUDE** information relating to HIV/AIDS, mental health, treatment and screening for alcohol, drug abuse or other substance abuse, sexually transmitted diseases and gene related impairments (genetic testing).

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subjected to re-disclosure and no longer protected by state and federal regulation.

EXPIRATION AND REVOCATION: I understand that this autorization is valid for 6 months from the date I sign it. I have the right to revoke this authorization in writing at any time. The revocation will take place on the day it is received, except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

NOT A CONDITION OF TREATMENT: I understand the Riverside Pain Physicians/Surgical Center or agency cannot condition treatment upon my signing this authorization.

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

_____ _____
Relationship to Patient Witness/Date

RIVERSIDE PERSONNEL ONLY:
Acknowledged by: (signature/date)

_____

Processed: ❑ Yes ❑ No

Number of pages: _____

Auth Release of Records ver 8_03_2011.doc