

**CLEARWATER PAIN MANAGEMENT ASSOCIATES, INC.**  
430 MORTON PLANT STREET \* SUITE 210  
CLEARWATER, FL 33756  
PHONE 727-446-4506 FAX 727-446-4695

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_-\_\_\_\_-\_\_\_\_ HEREBY  
Patient's Full Name Date of Birth Social Security Number

AUTHORIZE \_\_\_\_\_  
Name and Address of Facility Releasing Records

To release medical, including HIV antibody testing, Psychiatric/Psychological, alcohol and/or drug abuse information contained in my records to:

To: \_\_\_\_\_

Address: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I understand that if I consent to the release of any of my medical records, the results of any HIV antibody testing, Psychiatric/Psychological, alcohol, and/or drug abuse information will be released.

I understand this consent may be cancelled upon written notice to Clearwater Pain Management Associates, Inc., except to the extent that action by Clearwater Pain Management Associates, Inc. has been taken in reliance on this authorization, and that this authorization shall remain in force for 1 year period in order to effect the purpose for which is given. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law, FEDERAL REGULATIONS (42CFR, part 2) prohibit making any further disclosure of records without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. The confidentiality of HIV antibody testing is protected by Florida Law {Fla.Stat.ANN.381.609 (2) (F)} which prohibits any further disclosure by a person to whom this information has been disclosed, without specific written consent of the undersigned or as otherwise permitted by state law.

\_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent, Legal Guardian or Authorized Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness