# Clearwater Pain Management

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, _____/_____/_____, _____-____-_____
Patient's Full Name | Date of Birth | Social Security Number

**Hereby 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 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.

**This Authorization will expire in one year unless otherwise specified.**

_____ _____
**Patient Signature** **Date**

_____ _____ _____
**Parent, Legal Guardian or Authorized Representative** **Relationship to Patient** **Date**

_____ _____
**Witness** **Date**