COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA (CPCSFL)

2585 South State Road 7, Suite 110, Wellington, FL 33414
Phone (561) 795-8655 Fax (561) 795-8449

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Information			
Name (Last, First, MI)			
Phone	DOB	SSN	Email
Address			

A. **Records are to be: (Select One)**	**B.** **Records are for: (Select One)**	**C.** **Format: (Select One)**
☐ CPCSFL to **Send** Records ☐ CPCSFL to **Receive** Records Released From	☐ Self ☐ Organization **(Fill in section D)**	☐ Paper ☐ Electronic (via Secure Email for patients only) *requires email* ☐ Other_____

D. Organization *(Please send records to CPCSFL above fax or address)*

Phone	Fax
Address	

Information to be Released:	**Dates of Service To Release:**	**Released From :**
☐ Office Notes ☐ Operative Reports ☐ Lab Reports ☐ X-Ray/ MRI Reports ☐ Other _____	**From _____ To_____** *(If unspecified, the last 12 months of records will be released)*	☐ Keith Dietrick, MD ☐ Howell Goldfarb, MD ☐ Bruce Hindin, DO ☐ Humberto Porrata, MD

Authorization for General Release of Information

Initials _____ I understand that I have a right to revoke this authorization at any time. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire upon completion.

Initials _____ I hereby authorize release of my medical records which may include information relating to sexually transmitted disease, AIDS or HIV.

Initials_____I hereby authorize release in my medical records which may include information relating to behavioral or mental health services and treatment for alcohol and/or drug abuse.

Initials_____ Records requested for my personal use will require a charge of $1.00 per page for the first 25 pages, then $0.25 for each additional page pursuant to Florida Statute, Chapter 395.

Initials _____ Records sent to another medical provider will be sent free of charge.

Initials _____ If I choose to receive my records in an electronic format, I understand that I am authorized to use the email provided to Comprehensive Pain Care of South Florida.(*Patient Option Only*)

Signature of Patient/Legal Representative

Patient Signature_____ Date_____

Legal Guardian Signature _____ Date _____

Witness _____ Date_____

Office Use Only: Number of Pages: _____ Fee:_____ Initials_____

Comprehensive Pain Care of South Florida complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin age, disability or sex.
Comprehensive Pain Care of South Florida cumple con las leyes federales de derechos civiles aplicables y no discrimina por motives de raza, color, nacionalidad, edad, discapacidad o sexo.