CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

Edward Chen, M.D. Demetrios Kaiafas, M.D.
Michael Hux, P.A. Alphonso Fontaine, P.A., DHSc

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:

Facility/Individual & Relationship: _____

Address: _____

Phone Number:_____Fax Number: _____

For the purpose of: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

This Authorization will expire in one year unless otherwise specified.

A copy of this authorization is as valid as the original.

_____ _____
Patient Signature **Date**

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

_____ _____
Witness **Date**