Authorization for Release of Medical Information

Patient Name	Date of Birth

Release Information From:	Release Information To:
Name of Clinic/Hospital/Other Healthcare Provider	CENTRAL FLORIDA INTERVENTIONAL PAIN CLINIC
Street Address	1720 SE 16th Street, Unit 304 Ocala, FL 34471
City State Zip Code	Phone: (352)559-0354 Fax: (855) 428-0627
Phone Number Fax Number	

**For Continuity of Care, please release ALL Medical Information for the above-named patient including:

☐ *Pertinent Past and Present Information* **OR**

☐ *Specific Dates of Treatment* _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Specific Authorization to Release Sensitive Records I understand that this consent is to include disclosure of:

☐ HIV/AIDS ☐ Psychiatric Records ☐ Alcohol and/or Drug Abuse Records ☐ Sexually Transmitted Disease Information

I hereby authorize the release of the medical records referenced above to Absolute Elder Care as they are needed for continuity of care throughout the course of ongoing treatment. I understand this authorization constitutes a waiver of any claims that I may have against the provider(s) listed, and/or any of their agents/employees, as a result of their compliance with this request and that neither the provider(s) nor their agents/employees shall have any responsibility for acts or omissions concerning said records or their release after the records are made available.

Patient or Legal Representative Signature **Date**

Legal Representative Printed Name & Legal Designation Granting Authority to Sign on Behalf of Patient