AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

1301 Plantation Island Drive South, Suite 302A, Saint Augustine, FL 32080
Phone: 904-461-9330 ◊ Fax: 904-461-9331 ◊ Cell: 312-952-4422

Patient Name:_______________________________________ Birth Date__________________________

Address:____

Home Phone: ____________________ Cell Phone: ___________________ Alternate: ________________

I hereby authorize to release my: Paper Record Electronic Health Information

I authorize the release of relevant medical records from prior providers including but not exclusive to:
Primary Care, Family Medicine, Internal Medical, General Surgery, Orthopedic Surgery, Neurosurgery, Spine Surgery, Pain Management, Neurology, Physiatry, OB/GYN, Cardiology, Cardiac Surgery, Vascular Surgery, Podiatry, Psychiatry, Physical Therapy, Occupational Therapy, Chiropractor, Radiology, Laboratory Testing

Other:____

To: Dr. Adnan Faruqi
Advanced Pain and Spine Institute of Florida
1301 Plantation Island Drive South
Suite 302A
Saint Augustine, FL 32080

Phone: 904-461-9330
Fax: 904-461-9331

Purpose of Release: Continuing Care Legal Insurance Patient Request
Other: ____

Please release the following information contained in my medical records regarding my care and treatment:
Office Visits Operative Reports Labs/date drawn: ________________________
Immunizations XRays MRIs CT scans Other:_______________
Dates of Service: ______________________

If sensitive information is checked, patient must initial
HIV/AIDS information _____ Drugs and Alcohol _____ Psychiatric: ______ Other: ______

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, and/or AIDS (Acquired Immunodeficiency Syndrome) information, any may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, or facsimile machine (fax) or any other approved means. I understand I have the right to revoke this authorization at any time and must do so via written request. I understand that the revocation will not apply to information that has already been released as requested by this authorization. I understand that any disclosure of information carries with it a potential for redisclosure where confidentiality laws or regulations may not apply. I also prohibit Advanced Pain and Spine Institute of Florida from making further disclosure without the specific written authorization of the person to whom it pertains.

Release of PHI Expiration (If not indicated, will default to 1 year from this release)
Upon Death Expiration date: _______ One year from date of signature

____ ______________________

Signature of Patient or Legal Representative/Authorized Health Surrogate Date