Total Pain & Spine Care of Florida

MEDICAL RECORDS RELEASE FORM

Patient Name:_____ Date of Birth:_____

Phone Number:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.

Initials: Date:

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Name: Total Pain & Spine Care of Florida
Address: 2310 N Blvd W, Suite A, Davenport FL 33837
Phone: 863-732-7246 (PAIN)
Fax: 863-256-2520

I do give permission for these records to be faxed to the above entity.

Please forward:

_____Office Visits _____Initial History and Physical _____MRI Reports

_____Lab Reports _____Correspondence _____Insurance Information

_____Other (please specify)_____

Patient Signature: _____Date:_____