FLORIDA PAIN INSTITUTE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____
Last First Middle

Date of Birth: _____

Home Address: _____
_____, FL _____

Phone Number: _____

MY HEALTH INFORMATION TO BE DISCLOSED:
By signing this authorization, I authorize Florida Pain Institute to disclose the following health information about me:

☐ A copy of my entire medical record and any other health information about me maintained by Provider.

☐ Other (Please describe): _____
_____

MY SENSITIVE INFORMATION TO BE DISCLOSED:
By checking any of the boxes below, I specifically authorize the Provider to use and disclose the type of information indicated next to the box pursuant to this authorization:

☐ Information about mental health services

☐ Information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered, performed or reported)

☐ Information about sexually transmitted diseases

☐ Information about alcohol or drug abuse treatment program services

☐ Information about DNA analysis or other genetic test results or information

RECIPIENT: Name of person or class of persons who may receive my health information from the Provider: _____

Address of the Recipient or delivery location: _____
_____

TERM: This authorization will remain in effect:

☐ From the date of this Authorization until _____ _____, 20_____

☐ Until the Provider fulfills this disclosure request

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE: The Provider is authorized to use or disclose my health information identified above to the Recipient for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this authorization):

_____

I understand that once the Provider discloses my health information to the Recipient, the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. Any third party may not be required to abide by this Authorization or applicable federal and state law protecting the privacy of my health information. I understand that the Provider will not receive remuneration from a third party for the use or disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Provider's treatment of me.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Provider at the address listed below. The revocation will be effective immediately upon the Provider's receipt of my notice of revocation, except that the revocation will not have any effect on any use or disclosure of health information or other action taken by the Provider in reliance on this Authorization before it received my notice of revocation.

If I have questions or wish to revoke this authorization, I may contact:

Monica Aliberti
Vice President of Physician Practice Operations
813-872-4492

I have read and understand this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Provider to use or disclose my health information (including the specified categories of my sensitive information) in the manner described above.

_____	_____	_____, _____
Signature of Patient	Month	Day Year

If the patient is a minor or is otherwise unable to sign this Authorization, I, _____, authorize the Provider to use or disclose the patient's health information (including the specified categories of sensitive information) in the manner described above.

_____	_____	_____, 20_____
Signature of Personal Representative	Description of Authority	Date