Mauna M. Radahd, M.D.
Nicole Burns, D.O.
Michael Worobel, D.O.
Jason Tse, D.O.

PAIN MEDICINE GROUP

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION
Pursuant to 45 CFR 164.508

To: Pain Medicine Group and Associates

☐ 5741 Bee Ridge Road, Suite #250	☐ 1000 W. Broadway, Suite 208	☐ 13782 Plantation Rd, Suite101
Sarasota, FL 34233	Oviedo, FL 32765	Ft. Myers, FL 33912
Phone: (941) 365-5672	Phone: (407) 332-1400	Phone: (239) 277-7611
Fax: (941) 365-5854	Fax: (407) 332-4409	Fax: (239) 277-7608

Patient Name: _____ DOB: _____

I hereby request and authorize the disclosure of all protected information for the purpose of review and evaluation. I request the Pain Medicine Group to obtain full and complete protected medical information including the following:

( ) All medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, emergency room, progress notes, nurses notes, clinic records, treatment plans, discharge summaries, test results, questionnaires/history, correspondence and records received by other medical providers including psychiatric records, radiology records including MRI, CT Scans, EMG and laboratory results.

( )I understand the information to be released/disclosed may include information relating to AID, HIV, and alcohol and drug abuse. I authorize the release/disclosure of this type of information.
This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions have been considered and waived.

I understand the following:

a. I have the right to revoke authorization in writing at any time, except to the extent information has been released in response to the authorization.
b. The information released in response to the authorization may be re-disclosed to other parties.

Authorized Representative: ( ) Parent ( ) Surviving Spouse ( ) Legal Guardian/Administrator/Executor*
*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

_____ _____
Signature or patient or authorized representative Date signed

_____ _____
Name and Relationship of legal authorized representative Date signed

In the event these records are being requested other than for the use of the patient or attending physician, a charge of $1.00 per page will be assessed in accordance with Florida State Statute 395.3025.