FIRST CHOICE PAIN CARE CLINIC
Authorization For Release of Protected Health Information (PHI)

Name of Patient_____________________________ D.O.B.___________________

I. The undersigned patient, named below, hereby executes this authorization in compliance with Federal Health Insurance Portability and Accountability Act, HIPPA, 45 CFR 164.104.

II. The undersigned patient, named below, hereby executes this information in compliance with the Federal regulations governing Confidentiality and Drug Abuse Records, 42 CFR, Part 2.

III. This authorization is directed to the following healthcare provider(s) (including its agents, employees and associates):

1.
2.
3.

IV. The above named healthcare provider is requested to release the protected health information (PHI) that is described below, to the patient's pain management doctor:

☐ **First Choice Pain Care Clinic**	☐ **First Choice Pain Care Clinic (SWFL)**
401 Commercial Court.	**13100 Westlinks Terrace**
Suite D	**Suite 12**
Venice, FL 34292	**Ft. Myers, FL. 33913**
941-480-0200	**239-332-2360**
Fax: 941-485-8404	**Fax: 239-332-0830**
Attn: Donna	**Attn: Trisha**

Michael G. Yaffe, M.D.
Joel R. Sukonik, M.D.

V. The protected health information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by **First Choice Pain Care Clinic**. If you are a physician or an out-patient clinic, you are authorized to send your entire chart upon our request, including not only dictated handwritten notes, but outside medical records or correspondence maintained in my chart. If you are a hospital or medical clinic, you are authorized to release my complete records including x-rays, MRI, or related studies, office notes, face-sheets, history and physical, consultation notes, intra-operative records, operative reports, pathology reports, medication administration records, therapy notes, physician orders, progress notes, laboratory notes, intake/output records, reports of all x-rays, CT scans, MRI or PET scans, emergency room records, transfer records, anesthesia records, admitting summary, discharge summary, clinic records, pharmacy and drug records, concerning any medical treatment I have received from you at your institution. I hereby authorize release of all records to include mental health, chemical dependency and any Federal and State protected information under Florida Statute 394.459(9) (Psychiatric Information),

Name of Patient________________________________ D.O.B.___________________

Florida Statutes 397.053 and 396.112 (Drug and/or Alcohol Abuse information) and Florida Statute 381.609(2), Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome or tests for sexually transmitted diseases.

The records include, but are not limited to the following items:

Physician progress/care notes
Discharge summary
Most recent history and physical
Pre/Post operative reports
Diagnostic reports (MRI, CT scan, X-ray to include Dx)
Laboratory services and reports
Medication administration records
Other:

VI. REQUIRED DISCLOSERS-45CFR 164.508(C)

i. This protected health information is to be used for the following purpose: Treatment of Pain Management Services.

ii. This authorization may be revoked by a signed and properly dated written revocation, delivered to the healthcare provider named above, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

iii. The undersigned acknowledges that a refusal to sign this form will not result in a denial of pain management services by **FIRST CHOICE PAIN CARE CLINIC** and that this release not be coerced by this health care entity or any of its business associates.

iv. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

v. This authorization will expire twenty four (24) months after the date executed, unless it's revoked earlier in writing.

Patient Signature____

Print Name____

Patient Phone #: ____

D.O.B. _______/________/________ SSN _________ - _________ - __________

Witness________________________________ Date_______/________/________

Attached is a Medical Records Release Form

This form will allow First Choice to access your medical records from other medical facilities.

Step 1) Fill in blanks at top of both pages (Name and Date of Birth).

Step 2) Fill in blanks at bottom of 2nd page and sign (anyone you know can witness).

Step 3) Do not fill in any other blanks

Step 4) On a separate paper tell us what medical facilities have treated you; please include phone #'s for each facility you list.

Step 5) Fax or send to the office you wish an appointment at:

- [ ] **First Choice Pain Care Clinic**
  401 Commercial Court.
  Suite D
  Venice, FL 34292
  941-480-0200
  Fax: 941-485-8404

- [ ] **First Choice Pain Care Clinic (SWFL)**
  13100 Westlinks Terrace
  Suite 12
  Ft. Myers, FL. 33913
  239-332-2360
  Fax: 239-332-0830

******YOU MUST BRING TO YOUR INITIAL**** APPOINTMENT A 1 YEAR PRESCRIPTION HISTORY FROM EACH AND EVERY PHARMACY YOU HAVE USED IN THE LAST YEAR. THE PHARMACIES' WILL SUPPLY THIS TO YOU AT NO COST.**

YOU MUST ALSO BRING A VALID STATE ISSUED PHOTO ID. If you are new to the state a State of Florida issued photo ID will be required by first follow up appointment.

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