



## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: \_\_\_\_\_

I authorize release of my health information records to Tampa Pain Relief Center to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:

**TAMPA PAIN RELIEF CENTER**  
**4730 N HABANA AVE. SUITE 104**  
**TAMPA, FL 33614**  
**OFFICE: 813-872-4492 FAX: 813-870-1502**

(List of all facilities, clinics, and offices from which information will be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

	Physician's Name	Address	Phone Number
1.			
2.			
3.			
4.			

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

	Pharmacy Name	Address	Phone Number
1.			
2.			
3.			
4.			

HOSPITAL AND OTHER FACILITIES (for surgeries/procedures, MRI/CT SCANS and any LAB and X-RAY reports)

	Facility Name	Address	Phone Number
1.			
2.			
3.			
4.			

Restrictions:

\_\_\_\_\_ There are NO restrictions on the information that can be released.

\_\_\_\_\_ The following information CAN NOT be released:  
\_\_\_\_\_

DURATION:

This authorization shall be effective immediately. I understand this authorization to release medical records will become invalid when I am no longer a patient of Tampa Pain Relief Center. I understand I have the right to revoke this authorization, at any time by sending written notification to the Privacy/Compliance Officer at the above listed address.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

(PLEASE PRINT) Name of patient or personal representative : \_\_\_\_\_

(PLEASE PRINT) If personal representative, describe authority: \_\_\_\_\_

(A COPY OF THE SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT)