Dr. Jeff Buchalter ● Dr. David Fairleigh ● Dr. Mark Larkins ● Dr. R. Kenneth Garrett ● Dr. Susan Giffee
Dr. Kacey Montgomery● Dr. Varun Rimmalapudi ● Dr. David Disanto ●
Bryan Boerjan, D.C ● Kendra Metcalfe, PT, DPT
Audrey Sisney, ARNP-BC ● David Downey, PA-C ● Donna Garrett, ARNP-BC ● Jamie Jackson, ARNP
Yelena Bianco, ARNP ● Jackie York, PA ● Taylor Morrison, PA

AUTHORIZATION FOR RELEASE OF INFORMATION FOR PURPOSES OF CONTINUITY OF CARE

PLEASE RELEASE:
❑ All information in medical record. I understand this information may include psychiatric/psychological, alcohol/drug abuse, Aids/HIV information as well as other sensitive health information and I expressly give my consent to release all information.
❑ Only the following types of information (please include dates):
____
____

Patient Name: ________________________________ DOB: ____________ Social Security: ______________________
Address: ____

This information may be used/disclosed for each of the following purposes: ______________________________
____

At my request (only the patient can check this box) ❑ For my health care ❑ For payment/insurance ❑ Other: ______________
Expiration date of release: ______________

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the recipient may re-disclose it and it may no longer be protected by HIPPA, a federal privacy law. This authorization is valid for ninety (90) days from the date of signature, unless other noted. This authorization only applies to treatment occurring before the date of the signature. I may decline to sign this authorization. I understand that I may revoke the authorization in writing at any time. If I revoke the authorization, the revocation will not apply to the information that has already been released in response to the authorization. I understand the medical facility has 30 days to provide a complete copy of my medical record. I understand that the patients' healthcare and the payment for the patients' health care will not be affected if I do not sign the form. I understand that I may see and copy the information described on this form if I ask for it and I may receive a copy after I sign it. Before requesting copies of medical records, please ask about the copy fee that by law may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above. As specified in the Florida Statues 395.3025 the facility is authorized to impose a charge for copying records. There will be a $1.00 per page charge for the first 25 pages. After which there will be $0.25 per additional page.

ADDITIONAL NOTES

____ _____________________________________
Signature of Patient (or Patients personal representative) Date

____ _____________________________________
Printed Name of Patient (or Patients personal representative) Date

PLEASE SEND RELEASE BY E-MAIL OR FAX TO:
Fax: (850) 476-7073 · Email: Medicalrecords@clearwaypain.com
4901 Marketplace Rd. Pensacola, FL 32504
Phone: (850) 484-4080