Fabian A. Ramos, MD
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Pain Relief Center of Florida

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I hereby request and authorize the Pain Relief Center to obtain the health records of:
Name _____ DOB _____

( ) All general medical records, including HIV/AIDS, substance abuse, and psychiatric records.

( ) Limited records (i.e. lab results, EKG, MRI, X-rays, CT, etc.)

To: Pain Relief Center of Florida, Dr. Fabian Ramos
100 3rd Avenue West, Suite #110
Bradenton, FL 34205

PROHIBITION ON RE-DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without the express written consent of the person to who such information pertains, or as otherwise permitted by state law. With regard to HIV/AIDS, substance abuse, or psychiatric records; a specific written consent is required – a general authorization for the release of medical or other information is NOT sufficient for this purpose.

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

_____ _____
Date signed Signature of patient or authorized representative

Authorized Representative: ( ) Parent ( ) Surviving Spouse
( ) Legal Guardian/Administrator/Executor*

*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility.