

PHI DISCLOSURE FORM

By signing this document, I authorize **Central Florida Pain & Rehab Clinic** to use and/or disclose certain protected health information (PHI), about me, to or from the parties listed below.

I _____, acting on behalf of _____ date of birth: _____,
SSN: _____, hereby authorize **Central Florida Pain & Rehab Clinic** to
() **OBTAIN** () **RELEASE** medical information via email, facsimile, or other appropriate source () **TO** () **FROM**:

(Person(s) or Entity(ies) to receive / release requested information)

(Address) (City, State, Zip Code) (Phone Number) (Fax Number)

1. The health information to be obtained / release is: Place an "X" in appropriate space(s).

- All Dr. Umpierre's Medical Records (notes, phone notes, testing, therapy, billing, etc.)
- Entire Medical Chart (Cover to Cover)
- Only periods of events from _____ to _____ (Dates)
- Psychological Records Drug/Substance Abuse HIV Information Toxicology Records
- Diagnostic Studies: ___ MRI ___ X-Rays ___ CT Scan ___ EMG
- Other (specify): _____

2. The purpose or need for the disclosure of information is:

- Continued Medical Care Legal Case Personal Use
- Other (explain): _____

3. This authorization will expire on _____.

Please indicate expiration date for specific event (if authorization is not revoked or no expiration date is noted, it will terminate a year from the date of signature below).

4. I understand that I have the right to revoke this authorization at any time and must do so in writing. The revocation will not apply to PHI that has already been disclosed. I understand that revocation will not apply to my insurance company.

I understand that this practice may or may not receive payment or other in exchange for disclosing PHI.

I understand that the release, use, or disclosure of my protected information carries a potential for re-disclosure by the recipient and the PHI may not be protected by the Federal HIPAA Privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from legal liability that may arise from the release or receipt of the information requested.

Patient Signature / Legal Guardian

Relationship to the patient

Date Signed

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.