Multidisciplinary Pain Management & Regenerative Medicine

MEDICAL RECORDS RELEASE FORM

Patient Name: ____ Date of Birth: _____________________________

Phone #: ____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by initialing this form, I am specifically authorizing the release of this information. _______________________ Initial

By signing this form, I authorize you, **Dr. Richard Gayles/Nona Medical Arts** (Physician Name or Clinic

Name) Phone #: **407-412-5030 Fax**: **407-601-7946** to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Release my protected health information to the following person(s) entity:

Name: ____

Street____

City: ________________________________ State: ______________________________ Zip: _____________

Phone #: ____ Fax #: _____________________________________

I **DO** give permission for these records to be faxed to the above entity.

The reasons or purposes for this release of information are as follows:
Office notes, MRI, CT, and/or actual X-Ray films, Procedure notes ______________________________________.

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____ ____
Patient Signature (or legal representative) Date

9145 Narcoossee Road, Orlando, FL 32827
Phone: (407) 412-5030; Fax: (407) 601-7946