MEDICAL RECORDS RELEASE FORM

Patient Name:_____

Date of Birth:_____ Phone Number:_____

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 that release of this information.

Initials: _____ Date: _____

By signing this form, I authorize you 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:

EXCEL Pain and Spine
Phone: (813) 701-5804
Fax: (813) 291-7615
documents@excelpainandspine.com
www.excelpainandspine.com

SUN CITY CENTER: 771 Cypress Village Blvd. Sun City Center, FL 33573
WAUCHULA: 326 South 6th Ave Wauchula, FL 33873
ELLENTON: 7032 US-301 North Ellenton, FL 34222
LAKELAND: 1417 Lakeland Hills Blvd Suite 201 Lakeland, FL 33805
DAVENPORT: 2310 North Blvd W Suite A Davenport, FL 33837
WINTER HAVEN: 400 Ave. K SE Suite 9 Winter Haven, FL 33880

I do give permission for these records to be faxed to the above entity. Please forward:

_____Office Visits _____Initial History and Physical _____MRI Reports

_____Lab Reports _____ Correspondence _____Insurance Information

Other (please specify):_____

Patient Signature: _____ Date:_____