Central Florida
Pain and Rehab Clinic
Working together to improve your quality of life

3727 N. GOLDENROD RD., STE 103, WINTER PARK, FL 32792
Phone: (407) 673-9533 * Fax: (407) 673-1442
www.cfprc.com

PHI DISCLOSURE FORM

By signing this document, I authorize **Central Florida Pain and 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: _____, hereby authorize **Central Florida Pain and Rehab Clinic** to **(X)OBTAIN ( )RELEASE** medical information via email, facsimile, or other appropriate source **( )TO (X)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.