Dr. Michael Willens
3003 Claire Lane, Building 100
Jacksonville, FL 32223
904-683-2596 (o)
904-683-2597 (f)

HIPAA-COMPLIANT RELEASE AND GENERAL AUTHORIZATION
FOR RELEASE OF INFORMATION AND PROTECTED HEALTH INFORMATION

I authorize Advanced Pain Management Clinic, LLC.:

- ☐ To release my medical records to:
- ☐ To request my medical records from:

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The undersigned hereby authorizes to disclose, to furnish and to discuss with ADVANCED PAIN MANAGEMENT CLINIC, LLC. 5757 Booth Road, Building 100, Jacksonville, Florida, 32207, (904) 683-2596 (telephone), (904) 683-2597 (facsimile), the entire contents of any and all files and materials in your possession relating to the undersigned, for the records and dates specified below:

Medical records and Protected Health Information (PHI) including the following: hospital admission and discharge forms; dictated reports; physician's orders and progress notes; clinical or diagnostic test results; radiological or imaging studies; medications sheets; operative information; physical or occupational therapy records; nursing information and progress notes; mental health records, emergency room information; itemized billing records, memoranda or correspondence, transfer forms, history and physical, lab results, psychiatric/counseling, neurodiagnostic testing and rhythm strips and tracings, nursing records and **entire medical record or chart.** This shall include all medical, dental, osteopathic, podiatric and chiropractic records, charts and specially all psychological records as well.

Inclusive dates:_______________________________. (If not specified, include **all dates of service).**

I hereby acknowledge or consent to the release of information that may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that:

- I may refuse to sign this Authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.
- I understand that I have the right to revoke this authorization, in writing at any time except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that I uses and disclosures already made based upon my original permission cannot be withdrawn. I may revoke this Authorization at any time in writing, but if I do, it will not have any affect and documentation requested for purposes as may be required by them for any lawful use.
- I may see and obtain a copy of the information and documentation described on this form, for a reasonable copy fee, if I ask for it
- I affirm that I have received a copy of this form after I signed it.
- I am signing for myself, or in the event of a minor, as natural guardian of said minor.

A photocopy of this Authorization for Release of Information is binding and has the full force and effect as the original. This Authorization shall remain in effect until canceled by me in writing.

DATE:____________________________ SIGNATURE:____

NAME (Printed)____DOB____________________________________