AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

N	AME OF PAT	IENT										
D	ATE OF BIRT	Ή						SS#				
_	01 2							55				
T	O: (Name, Add	lress, Pho	one of Re	ecipi	ent o	of Records)						
N	ame	Pain Consultants of West Florida							Pho	ne	850-4	94-0000
A	ddress	4624 N. Davis Hwy										
C	ity/State Zip	City	Pensaco	ola	State			Florid	la		Zip	32503
	ECORDS FRO	M: (Who	o is Rele s	asing	g the	e Records)			DI			
	ame								Pho	ne		
	ddress		ı				I ~				1	T
C	ity/State Zip	City					State				Zip	
TC.	on the Fellowine	Dunnage	va.									
<u> </u>	or the Following Continued Med				Perso	onal Informatio	n		1.		egal Follow-up	
	Disability Insu				Other					1	8	
A	Please send	the entire	e Medical		rmation And/or Records Exist: ecord (all information) to the above							
	Office Notes	and Rep	orts		Diagnostic Reports					I	Billing Statements	
	Rx History					TD '1 1)	TT	1 D		-	1 .	D .
Т	Others Lister he Following I		ust Be In	nitial	•	Transcribed 1		•	•			e:
T	Others Listed	HIV/AID; Mental Ho Domestic Genetic T Drug/Alco	S relate in ealth Infor Violence esting Information	formation	led to	o Be Include and/or record nd/or Records and/or records	d in the	e Use A TB or O	nd/or ther Co	Dis	s closur nunicabl	e:
T	Others Listed	HIV/AID: Mental Ho Domestic Genetic T Drug/Alco much and	S relate in ealth Infor Violence esting Information bhol diagn what kind	formation of the format	led to	o Be Include and/or record nd/or Records and/or records tment or referr	d in the s HBV, al inform disclose	TB or O	nd/or ther Co	Dis	eclosur nunicabl	e: le Diseases require a description of how
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