



325 Clyde Morris Blvd Suite 400
Ormond Beach, FL 32174
(386)671-0600 Phone (386) 677-9710 Fax

900N. Swallowtail Dr. Suite 102
Port Orange, FL 32128
(386)756-2223 Phone (386) 756-2115 Fax

Patient Authorization

Patient's
Name _____

Date of
Birth: _____

Social Security
Number: _____

Phone #:1 _____ Phone #:2: _____

To Be Released To:

Advanced Pain Management
325 Clyde Morris Blvd Suite 400
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I, the undersigned, have read the above and authorize the doctors and staff of Advanced Pain Management, to disclose such information as herein contained, I understand this consent may withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge and hereby consent to such, that the released information may contain HIV testing, results and aids information, psychiatric, drug or alcohol abuse information. I also understand that any disclosure is bound by title 42 of the code of federal regulations governing the confidentiality of alcohol and drug abuse patient's records. Advanced Pain Management is released and discharged of any liability and the undersigned will hold Advanced Pain Management harmless for complying with this "Authorization for Release of Medical Information".

Patient's
Signature: _____ Date: _____