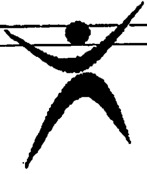


Interventional Pain Physicians *Nancy Erickson, D.O.*
Of South Florida

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please select either Option A or Option B

PLEASE PRINT

Option A:

I, ______________________________, authorize Interventional Rehabilitation of South Florida to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medical information and billing information) to the following named persons*:

1. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

2. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

3. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

* Only persons listed above will be able to receive information related to my care, such as treatment and billing information, co-payments, appointment times and test results. This office will not be able to disclose information to any other persons. (NOTE: You do not *have* to list anyone.)

I may change, expand or restrict this list at any time.

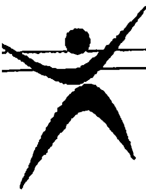
OR

Option B:

I, ______________________________, do not authorize Interventional Rehabilitation of South Florida to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medical information and billing information) to anyone but me personally.

Patient Signature: ______________________________ Date: ______________________

601 N Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: 433-8711♦ Fax: (954) 433-3646
www.flpainrelief.com



Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

Authorization for Pharmacy Release of Prescription Information

Patient Name: ______________________________ Date of Birth: __________

Address: ____

Phone #: ______________________ Social Security #: _________________

I authorize (Pharmacy Name, Address, Phone Number):

____

____

____

____

to release any and all medical information relating to my treatment from _________ to __________. This is to include all records, if any, concerning HIV or AIDS, mental behavioral health or psychiatric care, and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care.

☒ Records of Prescription Medications

Send information via Mail, Fax to: or Hold for pick-up by authorized Representative of:

Dr. Nancy Erickson
601 N Flamingo Road, Suite 411
Pembroke Pines, FL 33028
Phone: 954-433-8711 Fax: 954-433-3646

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Printed Name of Patient or Legal Guardian Relationship to Patient