Apex Pain Management

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Sanford, FL 32771
Phone: (407)323-9099 Fax: (407)323-4565

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I understand that, under Florida Law, the classification of records checked below relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and information consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me or my personal representative or otherwise provided by Florida Law.

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Social Security # _____

I authorize _____ to release health information to Apex Pain Management.

Please specify the health information you authorize to be released:

Dates of treatment: _____

_____X-Ray/CT/MRI Reports _____Lab Results

_____Physician Reports _____All Medical Records

_____ (initial) I understand this authorization to release health information is voluntary, Treatment. Payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization EXCEPT in the following cases: (1) to conduct research-related treatment. (2) To obtain information in connection with eligibility or enrollment in a health plan. (3) To determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

_____ (initial) I understand that the release of information by form or fax that confidentiality cannot be assured and I accept the risk that confidentiality may be breached when faxing information.

_____ (initial) I understand that if I authorize the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by Apex Pain Management or federal confidentiality laws.

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has a been taken pursuant to this authorization. I understand that if I revoke this authorization. I must do so in writing. Unless otherwise revoked, this authorization will expire 1 year from the date of the signature listed below.

_____	_____	_____
Print Name	Patient/Personal Representative Signature	Date
_____	_____	_____
Witness Print Name	Witness Signature	Date

Apex Pain Management Authorization for Release of Confidential Medical Information

Review of Systems: (Continued)

	Yes	No	Amount
Blood in Urine	_____	_____	
Nausea/Vomiting	_____	_____	
Chronic Cough	_____	_____	
Fevers/Night Sweats	_____	_____	
Urinary Tract Disorders/Infections	_____	_____	
Tuberculosis (TB)	_____	_____	
Morning Stiffness	_____	_____	
Joint Pain/Swelling	_____	_____	
Heart Murmur	_____	_____	
Rheumatic Fever	_____	_____	
Arterial Graft Surgery	_____	_____	
Chest pain	_____	_____	
Palpitations	_____	_____	
Shortness of Breath	_____	_____	
Increased Thirst	_____	_____	
Fainting/Dizziness/Vertigo	_____	_____	
Double Vision, Etc	_____	_____	
FEMALE:			
Hysterectomy	_____	_____	When _____ Partial/Total
Abnormal Vaginal Bleeding	_____	_____	
Last Menstrual Period			When _____
Endometriosis	_____	_____	
Nipple Discharge	_____	_____	
History of Breast Biopsy	_____	_____	
Last Pelvic Exam			When _____
MALE:			
History Prostatitis	_____	_____	
Difficulty in Urinating:	_____	_____	
Rectal Test	_____	_____	When _____Results_____
PSA Test	_____	_____	When _____Results_____

SOCIAL HISTORY:

Occupation: _____ Work Status: Full Duty _____ Light Duty _____
Off Duty _____ Unemployed _____ Retired _____

Tobacco Use Yes _____ No _____ Indicate Type and Quantity (Per Day) _____
Started (Age/Year) _____ Stopped (Age/Year) _____

Alcohol Use Yes _____ No _____ Indicate Type and Quantity _____

Have you ever been treated for substance?

	When
Dependency	_____
Abuse	_____
Addiction	_____

If yes, please circle which and indicate when.

Family History: Describe current health, cause of death, illness, diabetes, cancer, high blood pressure, etc.

Father: _____
Mother: _____
Siblings:_____

The preceding patient information has been reviewed and discussed with my patient.

_____ _____
Signature of Patient or Person Completing This Form Physician's Signature

- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I agree to random urine and blood tests to assess my compliance.
- I will not share, sell or trade my medication for money, goods or services.

_____ PT
- **I will safeguard (lockbox or safe) my medication from loss or theft, if I lose my prescription, spill or misplace my medication, I will be without my prescribed medication until my next scheduled visit.**

_____ PT
- **I am responsible for taking the medication in the dose prescribed, I will not raise the dosage without the doctors prior approval. Doing so may cause an overdose, and will lead to my running out of medication early.**

- Visits will be scheduled no earlier than 21 days and no later than 30 days and are required for management of the medications. Refills will be prescribed only on this schedule basis. and will not be called in over the phone.
- It should be understood by the individual that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. It should be known that children born when the mother is on Opiate therapy will likely be physically dependent at birth.
- In the event of an investigation I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor to fully cooperate with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This Agreement is entered into on this _____ day of _____, 20_____

_____ Patient

_____ Doctor

_____ Print Name

My signature above acknowledges my understanding and agreement with the above stated terms.