Wayne Weidenbaum, M.D.
INTERVENTIONAL PAIN MANAGEMENT
1411 N. Flagler Drive, Suite 4000
West Palm Beach, FL 33401
Phone: 561-833-0882 Fax: 561-833-0813

AUTHORIZATION TO RELEASE INFORMATION

PATIENT:_____ D/O/B_____

I hereby authorize _____ to release information from my medical record. This Authorization includes release of information, if any, concerning treatment of my medical and psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

I understand that the following medical information identified below relating to my treatment from _____ (date) to _____ (date) will be released:

___ Report for MRI of the (Cervical / Thoracic / Lumbar) Spine
___ Report for CT of the (Cervical / Thoracic / Lumbar) Spine
___ Consultation Notes from prior treatment sessions
___ Operative Notes from prior treatment sessions
___ Other (describe):_____
___ X-Ray Reports
___ Most recent Laboratory Results
___ Records of Prescription Medications
___History & Physical

The above information is requested for the purpose of pain management evaluation and treatment.

The above information is to be released to:

Wayne Weidenbaum, M.D.
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West Palm Beach, FL 33401
Phone: 561-833-0882
Fax: 561-833-0813

This Authorization must be signed and dated and may be revoked at any time by sending a written request to the privacy officer at the office of the disclosing physician or facility, except to the extent action has been taken prior to revocation. Revocation must be made in writing. Otherwise, this Authorization will expire six (6) months from the date of signature. I hereby state that I have read and fully understand the above statements as they apply to me. I acknowledge that I understand treatment, payment, or enrollment in any health plan or eligibility for benefits is not conditioned on signing this Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by federal privacy laws. I hereby authorize to the disclosure of the medical records to the purpose and extent stated above.

Signature of Patient or Patient's Legal Representative Date