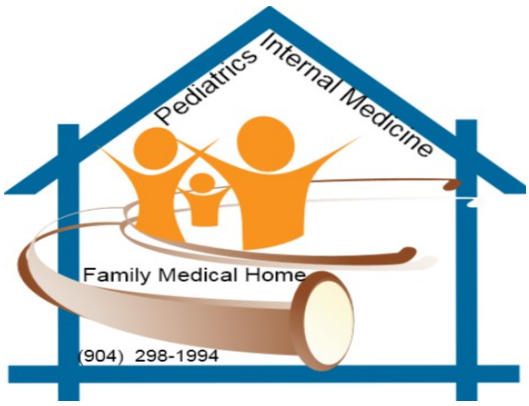
Doctors Inlet Internal Medicine, Spine & Pain
430 College Drive
Suite104-106
Middleburg, FL 32068
(904) 298-1994 Phone
(904) 298-1973 Fax



Avenues Internal Medicine,
Spine & Pain
10175 Fortune Parkway
Suite 401
Jacksonville, FL 32256
(904) 298-1994 Phone
(904) 298-1973 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____Date of Birth: _____
CurrentAddress:_____Phone#:_____

I,_____, hereby authorize:

Doctors Inlet Internal Medicine, Spine & Pain/Avenues Internal Medicine, Spine & Pain
_____disclose/release to _____obtain from

Name:_____Phone#:_____FAX#:_____
Address:_____
STREET CITY STATE ZIP

□ Date(s) of Service Requested _____
□ Full Record Release which may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

RESPONSE REQUIRED
Description of the purpose of the use and/or disclosure:

____Change of Provider	**____Second Opinion**	**____Emergency/Acute Care**
____Consultation	**____Insurance**	**____Social Security/Disability**
____Legal Purposes	**____Personal Use**	**____Other_____**

Describe

I have carefully read this consent, understand its contents and authorize the release of the above specified information. I understand this Authorization will remain in effect for one (1) year, but I may revoke it in any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization and that my ability to obtain treatment from Doctors Inlet Pediatrics and Primary Care, Inc., d/b/a Doctors Inlet Internal Medicine, Spine & Pain and d/b/a Avenues Internal Medicine, Spine & Pain will not depend in any way whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.
I understand that information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by State and Federal privacy regulations. I hereby release Doctors Inlet Pediatrics and Primary Care, Inc., d/b/a Doctors Inlet Internal Medicine, Spine & Pain and d/b/a Avenues Internal Medicine, Spine & Pain from any and all liability related to their reliance upon this Authorization of the release of information pursuant to this Authorization.

_____ _____ _____
Signature of Patient or Legal Guardian **Relationship** **Date**

_____ _____
Printed name of Patient or Legal Guardian **Witness**