



INFECTIOUS DISEASE CONSULTANTS

Infectious Diseases • HIV & Hepatitis • Wound Care • Travel Health • Outpatient Infusion

Main Office

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Patient Authorization To Discuss Protected Health Information (PHI)

DATE: _____

PATIENT NAME: _____

DOB: _____

The following named individuals have permission to discuss my PHI with my healthcare providers(s) and/or his office staff as my medical condition may require. This includes, but is not limited to, appointments, treatment plans, laboratory and diagnostic studies; and other information related to my medical care, including alcohol and drug abuse, psychiatric care, HIV and AIDS.

Printed Patient Name

Patient Signature

Person(s) authorized by patient to discuss PHI:

Name

Relationship

Name

Relationship

Diplomats in Internal Medicine and Infectious Diseases

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