INFECTIOUS DISEASE CONSULTANTS
685 Palm Springs Drive, Suite 2A
Altamonte Springs, FL 32701
Ph: (407) 830-5577
Fax: (407) 830-4164

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (PROTECTED HEALTH INFORMATION – PHI)

PATIENT NAME: _____ DATE OF BIRTH: _____ SS#: _____

By signing this authorization, I authorize any physician or practitioner of Infectious Disease Consultants MD PA to release certain protected health information (PHI) about me, including medical, alcohol, psychiatric, drug, HIV and AIDS, communicable and or sexually transmitted disease records to:

_____

_____

_____

This authorization permits the following individually identifiable health information about me to be released for the specified date or period of: _____ ***(Date entry or period MUST be entered)***

☐ My complete medical record ☐ All office notes ☐ All laboratory reports ☐ All diagnostic test reports

☐ Most recent office notes ☐ Most recent laboratory reports ☐ Other: _____
(Describe specifically)

This information will be disclosed for the following purpose: _____

This authorization will expire: _____ *(Enter date of expiration)*

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the federal Privacy Rule. However, alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by state regulations without the specific written consent from the patient.

I have the right to revoke this authorization, in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Infectious Disease Consultants, 685 Palm Springs Drive, Suite 2A, Altamonte Springs, FL 32701.

_____ _____
Patient Signature Date Printed name of patient

_____ _____
Signature of Guardian / Personal Representative Printed name of Guardian / Personal Representative

_____
Description of personal representative / guardian authority to act on behalf of the patient (parent, medical power of attorney, etc)

I acknowledge receiving a copy of this authorization: _____
Signature of Patient or Personal Representative / Guardian