Consultants in Infectious Disease, LLC

Diagnosis, Treatment, & Prevention of Infectious Diseases

CONSENT TO RELEASE INFORMATION

Patient Name_____**Phone Number**_____

Address_____**Date of Birth**_____

I HEREBY AUTHORIZE:

_____

Name of Person/Agency from whom information is requested

_____

Address of Person/Agency from whom information is requested

TO RELEASE MEDICAL INFORMATION TO:

_____

Name of Person/Agency Requesting

_____

Address of Person/Agency Requesting

Date

_____

Signature of Individual/Parent (if individual is under 19 years of age)/Legal Guardian

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check appropriate box below)

1. **Substance Abuse (alcohol/drug abuse)** ☐**YES** ☐**NO** ☐**NOT APPLY**
2. **Mental Health** ☐**YES** ☐**NO** ☐**NOT APPLY**
3. **HIV-Related Info. (AIDS related testing)** ☐**YES** ☐**NO** ☐**NOT APPLY**

_____

Signature of Patient of Legal Guardian

I authorize this information to be transferred by fax to_____

Fax number/or phone number_____**guardian/patient initials**_____

This authorization for release of information shall remain in effect until revoked in writing to this office.

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BELOW IS FOR PHYSICIAN USE ONLY

Medical information to be released to include the following:

This information was transferred by fax, mailed copies, or hand carried (circle one)
Date and initial_____