Infectious Diseases Associates
OF NORTH CENTRAL FLORIDA

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

DOB: ____________________ SSN#: ______________________

Address: ____

I hereby request and authorize: Infectious Diseases Associates of North Central Florida

To Obtain Records:

FROM: ____

Address: ____

Phone: ______________________ Fax: ______________________

Send Records:

TO: ____

Address: ____

Phone: ______________________ Fax: ______________________

Items Requested: ____

Dates of service: From: ____________________ To: ____________________

This records request is for the purpose of continuity of care. I understand that these records include diagnosis, treatment, and/or examination related to my health care and may include information related to drug/alcohol abuse, mental health, HIV testing and sexually transmitted disease when applicable. I understand that state law prohibits the re-disclosure without further consent. I understand this release will remain in effect for (1) year or until I revoke it in writing. I understand that I have a right to inspect and obtain a copy of all information released. I release Infectious Diseases Associates of North Central Florida and its employees from any and all liability that may arise from release of information as I have authorized. Signature on this authorization or refusal thereof will not have any effect on treatment at Infectious Diseases Associates of North Central Florida.

______________________________ ____________________

Patient Signature Date