Infectious Disease Associates of North Central Florida
3306 SW 26th Ave Suite 104, Ocala, FL 34471
P: 352-622-2020
F: 352-622-2025

# Authorization for Release of Medical Information

Name: ______________________________ DOB: ____________________

The above patient authorizes the following healthcare office to disclose records:

Office Name:______________________________________

Office Phone:________________________ Office Fax:______________________

Office Address:________________________________________________________

Reason for Request:
____ Referral
____ Continuation of Care
____ Change of Ins. or Provider
____ Other

____ Specific Information Requested:
_____________________________
_____________________________
_____________________________

The information will be disclosed to and used by the following organization:
INFECTIOUS DISEASES ASSOCIATES OF NORTH CENTRAL FLORIDA
3306 SW 26th Avenue Suite 104, Ocala, FL 34471
P: 352-622-2020 F: 352-622-2025

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present to our receptionist. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________________________ ____________________
Signature of Patient / Guardian/ or Authorized Representative Date

______________________________________
Print Name