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**AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION**

I, _____ hereby authorize
(Name of Patient)

(Name of Physician, Hospital, Individual or Agency)
to release medical, psychiatric, drug and or HIV testing, ARC, or aids information in my
records to: (Please provide complete name and address)

For the purpose of: _____
(Specific purpose for disclosure of records)

I understand that the specific reports shall include the following:

_____ Most recent office notes _____ All office notes
_____ Most recent lab reports _____ All lab reports

_____ Other: _____
(Describe specifically what information is to be released)

I understand that this consent is revocable upon written notice to the physician except to the extent that action by the physician has been taken in reliance on this authorization, and that this authorization shall remain in force for a reasonable time of _____, in order to affect the purpose for which it is given.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by the Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure of it 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 further disclosure by State regulations without specific written consent form the patient.

Date of Authorization

Patient signature in full

Date of Birth

Parent, Legal Guardian or Representative Signature