APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
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Authorization for Release of Protected Health Information

<u>*From our specialists to your providers***</u>**

Patient Name: _____ DOB: _____

Address: _____ SS# _____

_____

Phone # _____

To (for staff ONLY): Dr. _____

_____

_____

Phone: _____

Fax:_____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I _____ do I _____ do NOT authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be redisclosed by the recipient and may no longer be protected information.

This authorization will expire on _____ (date) or one year from date signed.

_____ Date: _____

Patient or Personal Representative's Signature