Infectious Diseases
EXPERT GROUP OF NW FLORIDA

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____
Last First M Maiden or other Name

Date of Birth: ____________________ Social Security Number: ____________________

Address: ____

Phone Number: ____________________ Alternate Phone: ____________________

( ) I hereby authorize Dr. Issa Ephtimios to release my medical records to myself, the physician and or the facility listed below:

Name: ____

Address: ____

Phone: ____________________ Fax: ____________________

( ) I hereby my request my medical records be release to Dr. Issa Ephtimios from the physician/facility listed below:

Name: ____

Address: ____

Phone: ____________________ Fax: ____________________

( ) All Medical Records ( ) History & Physical Exam ( ) Progress Notes ( ) Lab Reports
( ) Substance Abuse ( ) Mental Health ( ) HIV Related Information ( ) X-ray Reports
( ) Other

I understand that in compliance with the State of Florida statue, I will pay a fee of $1.00 per page. There is no charge for medical records if records are sent to facilities for ongoing care or follow up treatment.

____ ____________________
Signature of Patient or Parent/Legal Guardian/Authorized Person Relationship to patient Date