Atlas Infectious Disease Practice PLLC

# Atlas Infectious Disease Practice

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Board Certified, Infectious Diseases

PATIENT INFORMATION

**NAME:** _____ **DOB:** _____

**ADDRESS:** _____ **PHONE:** _____

I hereby authorize the protected health information regarding the above-named person to be forwarded:

| TO | **FROM** | **TO** | FROM |
|---|---|---|---|
| ATLAS INFECTIOUS DISEASE PRACTICE, PLLC | | PERSON/INSTITUTION: _____ | |
| 5401 S. CONGRESS AVE, SUITE 201 | | ADDRESS: _____ | |
| ATLANTIS, FL 33462 | | CITY/STATE/ZIP: _____ | |
| PHONE: (561) 995-6971 FAX: (561) 569-8309 | | PHONE: _____ FAX: _____ | |

Type of Information Requested

O Immunization/Shot Records O Operative reports, findings, and complications O Emergency treatment

O Complete Medical Record O Laboratory Reports O All Hospital Notes

O Prenatal Records O Radiology Reports of _____ O Billing Records

O Other _____

I specifically agree to the release of the following sensitive health information. I understand that for any of the following boxes that are checked. the health information released to the named recipient may include diagnosis, evaluation and/or treatment information for the following:

O HIV/AIDS O Alcohol and/or drug abuse O Behavioral health

**Purpose of Request:** O Continuing care O Personal O Legal O Other

**Dates of Service Requested:** O Most recent O From _____ to _____ O All

**Delivery Requested:** O Please hold for pickup O Please fax O Please mail

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Privacy Officer at this site of care, except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released. I understand that this authorization is voluntary, and I may refuse to sign this authorization. The above-named person/institution will not refuse to treat me based on whether I allow my health information to be used and disclosed by others. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations. This authorization shall remain valid unless revoked but will expire 90 days from the date of my signature or as otherwise specified by the dare, event or condition(s) as follows:

_____

Signature of Patient/Date

_____

Signature of Parent/Legal Guardian or Representative Relationship to Patient