

CONSENT FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE:

TO RELEASE MEDICAL RECORDS TO:

CENTER FOR PREVENTION AND TREATMENT OF INFECTIONS
BARBARA H. WADE, M.D.
EDGARDO E. LI-ESPINO, M.D.
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5153 N. NINTH AVE., SUITE 305
PENSACOLA, FL 32504
(850) 476-3131 FAX: (850) 476-4848

ON THE FOLLOWING PERSON:

NAME: _____

DOB: _____

SSN: _____

INDICATE ALL OF THE RECORDS AUTHORIZED TO BE INSPECTED/RELEASED BY
INITIALING RECORDS TO BE RELEASED BELOW:

- _____ A. Release of all medical records **EXCEPT** any information relating to HIV testing, AIDS, and AIDS-related syndromes; psychiatric and psychological information or alcohol and substance abuse treatment information related to my condition and care.
- _____ B. Release of all medical records **INCLUDING** any information relating to HIV testing, AIDS and AIDS-related syndromes relating to my condition and care.
- _____ C. Include any records of psychiatric and psychological information (mental health records) relating to my condition and care.
- _____ D. Include any records regarding alcohol and substance abuse treatment relating to my condition and care.

Include in above records: ___ Labs ___ X-rays ___ Progress Notes
 ___ Medications ___ Other _____

Patient or Guardian signature

Date

Witness

Date