

**CENTER FOR INFECTIOUS DISEASES, P.A.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

(Release of medical data includes redisclosure of medical information obtained from other providers)

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize \_\_\_\_\_ to release to Center for Infectious Diseases, P.A. pertinent medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness, or drug or alcohol abuse, and/or confidential HIV information to:)

\_\_\_\_\_  
\_\_\_\_\_

The nature and extent of information to be disclosed is (list dates of treatments, special reports, etc.):

\_\_\_\_\_

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.

This authorization shall expire 180 days after the date appearing below or 180 days after the patient's final treatment, whichever is later.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient/Legal Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
**HIV Related Information**

In the event that information released constitutes confidential HIV related information:

This information has been disclosed to you from records whose confidentiality is protected. Release of medical data includes redisclosure of medical information obtained from other providers.

20 Prospect Avenue, Suite 507  
Hackensack, NJ 07601

201 487-4088  
rv8/2/98  
rv 112299

Fax 201 489-8930