Anderson Allergy & Asthma

MICHAEL W. ANDERSON, M.D.
Board Certified Allergist • Adult & Pediatric Allergy & Asthma

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (INCLUDING HIV & AIDS RELATED INFORMATION)

Patient Name: _____ Date:_____

Date of Birth:_____ Daytime Phone:_____

I hereby authorize _____
(Name)

_____
(Mailing Address)

Phone: _____ Fax:_____

to release any information regarding my medical history.

❑ All ❑ Office Notes ❑ Labs ❑ X-rays ❑ Allergy Testing

The above records will include information regarding HIV/AIDS related testing or treatment, drug and/or alcohol abuse, and psychiatric treatment to be release to:

Michael W. Anderson, M.D.
63 West Underwood Street
Orlando, FL 32806
Fax: 407-839-4869

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Patient Signature:

_____ Date:_____

If the patient is a minor; and/or incapacitated, authorization must be signed by the parent or legal guardian. If the patient is deceased, authorization must be signed by the next of kin or executor on proof of same.

Legal Authorized Representative:

_____ Date:_____

Witness:

_____ Date:_____