CONSULTANTS
IN INFECTIOUS DISEASE

A Culture of Compassion

Steve Rademacher, MD
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Consent to Release Information to CID

Patient's Name (Last, First, MI) ______________________ ______________ _______

Address
Address 1 ____________________________ Address 2 ________________________
City __________________ State ___________________ Zip Code __________
Phone Number __________________ Date of Birth ___ /___ /___

I HEREBY AUTHORIZE:
Name of Person/Office from whom information is requested ___________________________

Address of Person/Office from whom information is requested
Address 1 ____________________________ Address 2 ________________________
City __________________ State ___________________ Zip Code _______________
Phone Number ______________________ Fax Number ________________________

TO RELEASE MEDICAL INFORMATION TO: **Years of Records Requested** ________
Consultants in Infectious Disease, LLC
1500 S 48th St, Suite 506, Lincoln NE, 68506
Phone: (402) 489-1110, Fax: (402) 489-8492

Signature of Individual / Parent (if patient is under 19 years of age) / Legal Guardian
Name _______________________________ Date ____________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
I specifically authorize the release of data and information relating to: (circle all that apply)

1.) Substance Abuse (alcohol / drug abuse)	YES	NO	NOT APPLY
2.) Mental Health	YES	NO	NOT APPLY
3.) HIV-Related Information (AIDS related testing)	YES	NO	NOT APPLY

Signature of Individual / Parent (if patient is under 19 years of age) / Legal Guardian
Name _______________________________ Date ____________

**** This authorization for release of information shall remain in effect until revoked in writing to this office. ****