CONSULTANTS
IN INFECTIOUS DISEASE
A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

Consent to Release Information to Outside Clinic

Patient's Name (Last, First, MI) _____ _____ _____

Address
Address 1 _____ Address 2 _____
City _____ State _____ Zip Code _____

I HEREBY AUTHORIZE CONSULTANTS IN INFECTIOUS DISEASE, LLC TO RELEASE MEDICAL INFORMATION TO:
Office Name _____

Office Address
Address 1 _____ Address 2 _____
City _____ State _____ Zip Code _____
Phone Number _____ Fax Number _____

Years of Records Requested _____

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. ****