 835 7th St Suite 5,

Clermont FL 34711

Office 352-404-8961

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Adolfo Teran MD

Ardiana M Teran CPNP,ARNP

Authorization to Release Healthcare Information

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize and request:

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

(Please Include Address and Phone Number)

to release healthcare information of the patient named above to:

*Name : Orange Doc Family Medicine Pllc*

*Address: 835 7th Street Suite 5*

*City : Clermont State: Florida Zip Code: 34711*

This Request and authorization applies to :

[] Healthcare Information relating to the following treatment, condition or dates:

[] All Healthcare Information

[] ED or Admission Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] All Imaging and Lab and or diagnostic testing

[]Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Definition: Sexually Transmitted Disease/ Illness (STD/STI) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus) , AIDS(Acquired Immunodeficiency Syndrome) , and Gonorrhea.

[] Yes [] NO : I authorize the release of my STD/STI results, HIV/AIDS testing, whether negative or positive to the persons listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before discloser of these test results to anyone.

This Release of Information will remain in effect until terminated by me in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient or Parent