COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Delta Internal Medicine Center
220 East Gore Street, Suite 201
Orlando, FL 32806

Patient Name: ____Date of Birth: _______________________

1. You may contact me via the following methods and I agree to received detailed messages regarding appointments, prescriptions, test results, referral information, billing information, or other information pertaining to my treatment and care:

   _____Preferred Phone Number ____
   _____E-Mail Address ____
   _____Cell Phone/Text Number ____

2. I authorize Delta Internal Medicine Center to release information about my medical condition and diagnosis (including treatment, payment, and health information) to the following family member or other persons (if any):

Full Legal Name	Relationship	Phone Number
_________________________________	___________________	__________________________
_________________________________	___________________	__________________________
_________________________________	___________________	__________________________

I understand that these records may contain information from other health care providers, as well as information which is administrative in nature. I specifically consent to the release of any information contained in my medical record which may relate to:

________Infection with Human Immunodeficiency Virus (HIV) _____ AIDS ________ Mental Health and any other related alcohol and substance use.

I understand that you have no responsibility of the use of distribution of this information by the party to whom it is released. I release you form all liability which may arise from your compliance to release records.

I authorize you to transmit this information by telephone, facsimile transmission (fax) and/or mail, and to release you form any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax. This release is valid for 1 year from the date signed.

__________________________________ ______________
Patient / Legal Representative Signature Date