Carlos I. Arias, M.D. PLC
Family Practice
5309 State Road 64 East • Bradenton, FL 34208
941-747-9818 • 941-747-9535 fax

Authorization for Release of Healthcare Information

Patient Name: _____

Date of Birth: _____

I hereby authorize the transfer of the following healthcare information:

TO: **Carlos I. Arias M.D., PLC**
5309 State Road 64 East
Bradenton, FL 34208
Phone: (941)747-9818 Fax: (941)747-9535

FROM: _____

_____

_____

_____

____ **Entire contents of chart**

OR (specify particular portions of chart)

____ **progress notes** ____ **pathology reports** ___ **lab reports**

Purpose of disclosure: ____ **transferring permanently** ___ **continuity of care**

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including HIV and AIDS.

_____

Signature of patient **Date**

_____

Signature of legal guardian **Date**