Allergy & Asthma Center of East Orlando

Boyce A. Hornberger, MD, FAAAAI
Diplomate American Board of Allergy and Immunology

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth _____

I request and authorize:

Name Boyce Hornberger MD

Address 3151 N Alafaya Tr Ste 103

City Orlando State FL Zip Code 32826

Phone 407-380-8700 Fax 407-380-7043

to release healthcare information of the patient named above to:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: _____

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

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, 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 any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____

Patient's Signature (Parent if under 18) Date Print Parent Name (if patient under 18)