



**AKLILU & COBIAN INFECTIOUS DISEASES, LLC
RELEASE OF MEDICAL RECORDS**



To: _____

Date: _____

Patient: _____

DOB: _____

Dates of Service: _____

Account # _____

The above named patient is currently be treated by: Dr. Cobian Dr. Aklilu

The patient has an appointment on: _____

Please fax to (954) 489-2261 ALL pertinent records you have on this patient. Including but not limited to:

| | |
|--|-----------------------|
| | Entire Medical Record |
| | Discharge Summary |
| | Lab Reports |
| | ECG Reports |

| | |
|--|----------------------|
| | History & Physical |
| | Operative Reports |
| | Microbiology Reports |
| | Progress Notes |

| | |
|--|-------------------|
| | Consult Reports |
| | Pathology Reports |
| | Radiology Reports |
| | Physician Orders |

I authorize and request the above named facility to furnish Aklilu & Cobian Infectious Diseases, information concerning my case history, treatment, examinations, etc. I understand that this disclosure may contain psychiatric, substance abuse, AIDS diagnosis and/or treatment, or HIV test results. I understand this information if faxed/mailed may be misdirected and Aklilu & Cobian Infectious Diseases shall be held harmless. The clinical information will be regarded as CONFIDENTIAL and will be used solely for the purpose of my treatment while I am a patient under their care.

Patient Signature: _____ Date: _____