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: _____

2151 East Commercial Boulevard, Suite 203, Fort Lauderdale, FL 33308
Telephone: (954) 489-2260 Fax: (954) 489-2261