Infectious Disease Consultants

Dr. Alvaro Lopez, M.D.
Dr. Andrew Dold, D.O.
Dr. Andrew Pugliese, M.D.
Dr. Elliot Raizes, M.D.
Dr. Karuna Kusan, M.D.
Dr. Paul Martin, M.D.
Dr. Roger Lovell, M.D.
Dr. Tzvetan Vassilev, M.D.

1960 Riverside Parkway, Suite 101
Lawrenceville, GA 30043
(770)939-1601 - Phone
(678)347-2059 – Fax
Contact@idcga.com- Email

Patient's Full Name: ______________________ Patients Date of Birth: ________________

I authorize Infectious Disease Consultants to:

☐ **To Release Copies to** ☐ **To obtain copies from**

Physician Name: ____

Address: ______________________________________ City and Zip: _______________

Check Information that may be released, note only records pertaining to your doctor's orders may be released.

☐ **Complete Chart** ☐ **Progress Notes** ☐ **Culture Results** ☐ **Lab Results** ☐ **CT/MRI Films**
☐ **Radiology Reports** ☐ **Medication list** ☐ **Surgery Notes** ☐ **Other:** ________________

This information is for the purpose of:

☐ **Continued Treatment** ☐ **Insurance** ☐ **Second Opinion** ☐ **Moving** ☐ **Other**

To be: ☐ **Picked Up** ☐ **Mailed** ☐ **Faxed to** ____________________________

I hereby authorize this practice to release my medical records, including, but not limited to all of the above. By signing this consent I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months.

______________________________ ______________________________

Patient/Guardian Signature **Date**

Fee for medical records start at $25.88, this doesn't include copying cost. Copying cost are as follows: for a records which is in paper form shall not exceed $0.97 per page for the first 20 pages of the patient's records which are copied, $0.83 per page for pages 21-100 and $0.66 for each page copied in excess of 100 pages. We will process your request upon receipt of said payment.

For Office Use Only

Records Paid $:__________on___/___/___ CASH CC Check #__________ Records Sent ___/___/___
Initials: ______________ Physician Signature: ______________________________