



**Meyer
Internal
Medicine**

Robert M. Meyer, M.D.

Diplomate, American Board of Internal Medicine

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize

(Phone and Fax number)

To release medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorders information or any other records of sensitive nature to:

Robert M. Meyer, M.D.
Meyer Internal Medicine
1781 Park Center Drive
Suite 120
Orlando, Florida 32835
Phone: (407) 297-3626
Fax: (407) 297-3772

For the purpose of _____
(Specific purposes for the disclosure of records.)

The specific reports to be disclosed shall include _____

I understand that this consent is revocable upon written notice to Dr. Meyer except to the extent that the action has already been taken on this authorization. This authorization shall remain in force until _____ or for a reasonable time to accomplish the purpose for which it is given. Alcohol and drug abuse information, if present, will be disclosed from records whose confidentiality is protected by Federal law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Date of Authorization

Patient Signature in Full

Date of Birth

Parent, legal guardian, power of attorney