

Nereida Diaz-Johnson, M.D.  
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Internal Medicine

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

Patient name: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone number \_\_\_\_\_ Work number \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Patients name) (facility)

located at \_\_\_\_\_  
(address and telephone number)  
\_\_\_\_\_

To release my medical records to: **Dr. Nereida Diaz-Johnson and/or Dr. Clark Philogene** of the Union Medical Group, LLC

**By signing below I indicate that I understand and consent to the release of documentation and/or reports in my Medical Record, which may include alcohol, drug abuse, AIDS/HIV infection and/or psychiatric conditions and treatment of these diagnoses. Patients aged 14 years and older must sign for consent to release their information.**

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_  
(Patient, age 14 or older)

SIGNED: \_\_\_\_\_

(Patient/Legal Representative/Relationship)