Medical Information

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: **DOB:**

Previous Name: **SS#:**

I request and authorize _____

to release healthcare information of the patient named above to:

Name: _____

Address _____

City: _____ **State:** _____ **Zip Code:** _____

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition, or dates:

_____

❑ All healthcare information

❑ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ Yes ❑ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ Yes ❑ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.