AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This authorization expires on ____/____/____ - 1 year from the date it is signed.

Patient's Name: ____ Date of Birth: ______/_______/_______

Previous Name(s): ______________________________________ SSN: _________/_______/__________

□ I ***Do Not Authorize*** the release of my medical records.

I request and authorize ____ to release healthcare information of the patient named above to:

Name(s):____

Address:____

Persons listed on this authorization will be required to present government issued ID for proof of identity and all fees must be paid in full before receiving documentation.

This request and authorization applies to: (*please √ all that apply*)

□ All healthcare information

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

□ 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 venereum, 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.

____ ____________________________

Signature Date