

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME		DOB	
PHONE #		LAST 4 SSN:	XXX - XX -

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

NAME					
ADDRESS					
CITY		STATE		ZIP	
PHONE #		FAX #			

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 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.

Purpose of disclosure:

Specialist Referral

Continuing Care

Updating Personal Records

Insurance Request

Change of Doctors

Other: _____

I realize that by signing this form that I am authorizing the release of my medical information. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it. I understand I may cancel this request at any time with a written notification. I understand there may be a charge for record copying services and I am responsible for paying these fees.

SIGNATURE

DATE

This authorization is valid for 12 months from the date signed