Authorization To Release Healthcare Information

Patients Name: ______________________________ Date of Birth: ____________________

Previous Name: ______________________________ Social Security #: __________________

I request and authorize ______________________________
(Name of Clinic or Physician)

____
(Address)

____
(Phone) (Fax)

to release healthcare information of the patient named above to:

____
(Name of Clinic or Physician)

____
(Address)

____
(Phone) (Fax)

This request and authorization applies to:

- ☐ Entire record
- ☐ Obstetrical record
- ☐ Only information related to ______________________________
- ☐ 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:** ____________________