AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date of Birth:_____ Patient Name: _____

Previous Name:_____ Social Security #:_____

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

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 7024 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis, VDRL, cancroids, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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. Yes _____ No_____

Patients Signature:_____

Date Signed:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.