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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

Address: _____

Phone#: _____ Fax#: _____
to release my healthcare information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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 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: _____

PROCESSING OF THIS REQUEST WILL REQUIRE A FEE OF $25.00 AND A MINIMUN OF 5-7 BUSINESS DAYS. FEE WILL BE WAIVED IF MEDICAL RECORDS ARE RELEASED DIRECTLY TO A HEALTHCARE PROVIDER. THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE ON WHICH IT WAS SIGNED.