

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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2765 Jefferson Davis Hwy, Suite 107, Stafford, VA 22554  
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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security# \_\_\_\_\_

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

\_ Healthcare information relating to the following treatment, condition: \_\_\_\_\_

Dates From \_\_\_\_\_ TO \_\_\_\_\_

\_ All healthcare information

\_ Other: \_\_\_\_\_

\_ Reason for leaving practice \_\_\_\_\_

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 780.24 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 Gonorrhoea.

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 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: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Providing Patients Charts=\$10 Service Fee plus 50 cents per page for the first 50 pages, 25 cents after 50 pages

Retrieving Charts From Storage=\$20 Service Fee

