

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

1011 Care Way, Fredericksburg, VA 22401
(540)373-4900 Fax: (540)373-5195

125 Hospital Center Blvd, Suite 315, Stafford, VA 22554
(540)659-1500 Fax: (540)657-2771

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Renee Carisio-Farber, M.D., FACOG

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 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 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



