UNIVERSITY OF NORTH CAROLINA
SCHOOL *of the* ARTS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize: Office name_____
Office address_____
_____
Office fax number_____
Office phone number_____

to release healthcare information of the patient named above to:

University of North Carolina School of the Arts, Health Services
1533 South Main Street
Winston Salem, NC 27127
(336) 770-3288; Fax (336) 770-1492

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 (Aquired 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: _____

Parent Signature: _____ Date: _____
(if student is a minor)

THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR AFTER IT IS SIGNED