Attention: ASIA MARTIN
4601 Charlotte Park Drive Ste. 390, Charlotte, NC 28217
Phone: 704.529.6161 Fax: 704.831.6097
Or email completed form to: asia.martin@healthstatinc.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Clinic Provider's Name: _____ Patient's Name: _____

Birthdate: _____ Social Security #: _____

I request and authorize Healthstat, Inc. to release healthcare information of the patient named above to the following physician or to patient at:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.