AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____
Previous Name(s):_____
Date of Birth:_____ Social Security #:_____

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

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____

This request applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:
_____

☐ All healthcare information

☐ Other:_____
_____

☐ **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.

Definition: Sexually Transmitted Disease (STD) is defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphullis, VDRL, chancriod, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ **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:_____