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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Alternate Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(If different from above)

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

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

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 (HPV), wart, genital wart, condyloma, Chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), 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: \_\_\_\_\_