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| **Authorization to Release Healthcare Information**  **[HOSPITAL/AUTHORITY NAME]** | [Doctor name] |

[Street address] | [City, ST ZIP Code]

Phone: [Phone number] | Fax: [Fax number] | [Email] | [Website]

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| Patient’s Name: [Current name] | Date of Birth: [DOB] |
| Previous Name: [Previous name] | Social Security #: [SSN] |
| I request and authorize [Authorized individual] to release healthcare information of the patient named above to: | [Name] [Street address] [City, ST ZIP Code] |

This request and authorization applies to:



[List here]



[List here]

[Additional information]

**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.

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|  | 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. |
|  | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. |

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| Patient Signature: |  | Date signed: [Date] |

### THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.