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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

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

Name: _____

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: _____

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.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. I understand that treatment and payment are not conditioned upon my consent to release information.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire in six months from the date signage.

☐ 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.

_____ _____ _____ _____
Signature of Patient: Date/Sign: Signature of Parent/Guardian: Date/Sign

_____ _____ _____
Signature of Witness: Date/Sign: Relationship