



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security Number: _____

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:

- All of healthcare information
- Other: _____

Confidential Statement: This information has been disclosed to you from records protected by Federal and State confidentiality rules. The Federal rules prohibit you from making any disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted. Any disclosure, copying, distribution, or taking of any action in reliance on the contents of this information is prohibited.

- 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.