



# Medical Records Release

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

I request and authorize: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to release healthcare information of the patient named above to:

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

- All healthcare information
- Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_
- Other \_\_\_\_\_

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, AIDS, and gonorrhea.

Yes  No I authorize 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 result 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: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Witness (If available) : \_\_\_\_\_

**This authorization expires two years after it is signed. The patient reserves the right to revoke this release at any time.**