AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:	Date of Birth:
Previous Name:	Social Security #:
Address:	City:
State:	Zip:

I authorize the release of my medical records from the medical office listed below:

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, conditions, 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, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient /Guardian Signature: _____

Date: _____

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