

AUTHORIZATION FOR BEYOND CARE PEDIATRICS 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 BEYOND CARE PEDIATRICS to 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 venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient /Guardian Signature: _____

Date: _____