



CONFIDENTIAL

6200 E. Hwy. 62, Building 2501, STE 250
Jeffersonville, In 47130
Ph. 812-214-0460
Fax 812-716-2026

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SSN: _____

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: _____

Definition: Sexually Transmitted Disease (STD) as define by law, RCW 70.24 et esq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, WDRL, chancroid, lymphgranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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