AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ____

Date of Birth: ___________________________

I authorize and request From: _____________________________________
Name of Physician or Medical Facility

____
Street Address

____
City State Zip

_________________ ___________________
Facility Phone Number Facility Fax Number

Release Records To: _____________________________________
Name of Physicians or Medical Facility

____
Street Address

____
City State Zip

_________________ ___________________
Facility Phone Number Facility Fax Number

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition or dates: _____________________________________

□ All Heathcare information

□ 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 venereum, 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.
I understand that my medical records of the patient for whom I am signing may include Alcohol/Drug abuse, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. Alliance Pediatrics, PA, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

___________________________________ ________________________ __________________
Patient Signature or Legal Representative Relationship to Patient Date