



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO THE PICHARDO CLINIC

Fill out this form if you want your records from your previous doctor be sent to our office.

Patient's Name: _____ Date of Birth: _____
 Previous Name: _____ SSN: _____
 Address: _____ City: _____
 State: _____ Phone: _____

I request and authorize release healthcare information of the patient named above from:

Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax#: _____

Records as listed below should be mailed or faxed to: **The Picardo Clinic**, to the address or fax listed at the bottom.

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 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 (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: _____

Witness: _____ Date Signed: _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS AUTHORIZATION IS VALID FOR UNTIL REVOKED IN WRITING BY ME.



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