



## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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 to:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_

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 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.

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.