

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Pauline Miller MD to release healthcare information about the above named patient to:

Name/Entity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

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

All health information

Other: _____

Definitions: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the release of my STD result, 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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 IS IT SIGNED.