Juneau Women's Health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ Date of Birth _____

SSN _____ Address _____ City _____

State _____ Zip _____ Phone _____ Email _____

I request and authorize: _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

to release healthcare information to: Juneau Women's Health

Address 1601 Salmon Creek LN,#7 City Juneau State AK Zip 99801

Phone (907)723-8222 Fax (907)206-5666 Email alixcurtain@juneauwomenshealth.com

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates _____

_____

_____

☐ 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.

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 tests 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.

☐ Yes ☐ No

Patient Signature_____ Date _____