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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Date of Birth: _____

I request and authorize _____
Address: _____
Phone Number _____ Fax_____
To release healthcare information of the patient named above to Kiddie Health Pediatrics.

This request and authorization applies to:
___ Last wellness visit & recent lab records (**Please send via mail**)
___ Immunization record **(FAX to 410-687-0070)**
___ Healthcare information relating to the following treatment condition or dates: _____
___ Other: _____

Definition: Sexually Transmitted Infection (STI) as defined by laq, RCW 70.24eq. seq., Includes herpes, herpes simples, human papilloma virus (HPV), wart, genital wart, condyloma, Chlamidia, 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 STI 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/Parent /Guardian Signature _____ Date signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.