DIVERSITY HEALTH CENTER

☐ 303 Fraser Drive Hinesville, GA 31313 912-877-2227 Fax: 912-877-2332
☐ 213 N. McDonald St. Ludowici, GA 31316 912-545-9398 Fax: 912-545-2747
☐ 502 E. General Stewart Way, St. A, Hinesville, GA 31313 912-368-1959 Fax: 912-368-1966
Mailing Address for all locations: Post Office Box 1520 Hinesville, GA 31310

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____Date of Birth: _____

Previous Name:_____Social Security #: _____

I request and authorize:

(**your current doctor)**_____Phone #: _____

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City:_____State:_____Zip Code:_____

This request and authorization applies to:

☐ Healthcare information relating to the treatment, condition, labs, consults, diagnostics information etc.
☐ 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 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 drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____Date Signed:_____