Nokesville Medicine, PC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____
to release healthcare information of the patient named above to Nokesville Medicine.

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 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 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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED