Pecos T. Olurin M.D.

1403 North Rodney Street, Wilmington, DE 19806
Phone: 302.654.4800 Fax: 302.984.0440

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: Pecos T. Olurin M.D.

Address: 1403 North Rodney Street

City: Wilmington State: DE ZIP Code: 19806-4218

This request and authorization applies to:

☒ Health care information relating to the following treatment, condition, or dates:

_____

☐ All health care 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 venereum, 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 SIX MONTHS AFTER IT IS SIGNED.