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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous (maiden) Name: _____

Requesting Records [] To [] From: _____

Releasing Records To: [] Ebunoluwa Wion DO (AffirmHD) [] Other: _____



I request and authorize the release of the following healthcare information of the above named patient:

- [] All healthcare information
[] Healthcare information relating to the following treatment, condition, or dates:

[] Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, 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.

Signature: _____

Printed name: _____

(Circle one: Patient, parent, guardian, or authorized representative)

Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.