Park Primary Care Associates

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ **Date of Birth:**_____

Previous Name:_____ **Social Security #:**_____

I request and authorize(ie.Dr. Rosen/Somer)_____ **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 following treatment, condition, or dates: (You must specify in years----"ALL" will not be accepted)**

_____

_____

☐ 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, syphillis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ **Yes**	☐ **No**	**I authorize the release of my STD test results, HIV/AIDS test results, whether negative or positive, to the pereon(s) listed above. I understand that the person(s) listed above will be notified and that I must give specific written permission before disdosure 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.**
☐ **Yes**	☐ **No**	**I authorize the release of my Tuberculosis Information.**
☐ **Yes**	☐ **No**	**I authorize the release of any genetic information and/or psychotherapy notes.**
☐ **Yes**	☐ **No**	**I authorize the release of any activities where we receive money and/or marketing activities.**

Patient Signature/Personal representative:_____ **Date signed:**_____

This authorization expires 90 days after it is signed