AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
| Address: |  | Social Security #: |  |
| I request and authorize |  | to |
| release healthcare information of the patient named above to: |
|  | Name: | Central Bucks Rheumatology |
|  | Address: | 1456 Ferry Road, Suite 403 |
|  | City: | New Britain | State: | PA | Zip Code: | 18902 |
| 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, 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. |