

TRINITY MEDICAL ASSOCIATES

410 Foulk Rd, Ste 200B Wilmington, DE 19803
5209 W. Woodmill Dr. Suite 35 Wilmington, DE 19808
P: 302-762-6675 F: 302-762-6695



AUTHORIZATION TO RELEASE HEALTHCARE/MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

I request and authorize:

Doctor's name or Practice Name: _____

Phone Number: _____

Fax Number: _____

To release healthcare information of the patient named above to:

Trinity Medical Associates
5209 W. Woodmill Dr. Suite 35 Wilmington, DE 19808

This request and authorization applies to (check the box):

Healthcare information relating to the following treatment, condition or dates:

All healthcare information (including ALL office/clinical notes, ALL test results, ALL clinical data from both paper & electronic chart)

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, human papillomavirus, wart, genital, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS and gonorrhea:

Yes No I authorize 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.

Yes No I authorize the release on any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____

Date: _____