

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

- FMLA &/or Disability(\$15/ form)
- Transferring Care
- Prenatal Review
- Continuation of Care

Patient Phone No: \_\_\_\_\_ Reason for Release: \_\_\_\_\_

I request and authorize **Valley Ob-Gyn Clinic, P.C.** to release records to:

Release To:	
Address	
Phone/Fax No.	

This request and authorization apply 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 UNLESS REVOKED IN WRITING SOONER BY PATIENT OR PATIENT'S AUTHORIZED GUARDIAN OR LEGAL REPRESENTATIVE.