IntegrativeMedical OF COPPELL

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I hereby authorize:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release medical information from the health record of:

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Information is to be release to:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

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