CONFIDENTIAL
1720 Lafayette Rd. STE A
Crawfordsville, In 47933
Ph. 765-323-4689
Fax 765-362-8222

Authorization to Release Healthcare Information

Patient Name: _________________________________ Date of Birth: _________________________

Previous Name: ________________________________ SSN: __________________________

I request and authorize ____ 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:

____

All healthcare information

Other: ____

Definition: Sexually Transmitted Disease (STD) as define by law, RCW 70.24 et esq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, WDRL, chancroid, lymphgranuloma 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