PERITO UROLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Last Name: _____ **First Name:** _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I request and authorize _____ to release healthcare information of the patient names above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to: _____

*Healthcare information in relation to the following treatment, condition, and date:

_____

*All Healthcare Information_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq, includes herpes, Herpes simplex, human papilloma virus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL candroids lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

YES NO **I authorize the release of my STD results, HIC/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed aboive 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, and or mental health treatment to the person(s) listed above.**

PATIENT SIGNATURE: _____ **Date:** _____