NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

Physician Office Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to:

□ All healthcare information.

□ Healthcare information relating to the following treatment, conditions, or dates: _____

_____

□ Other: _____

Definition: Sexually transmitted diseases (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 my records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____

Patient Signature Date