

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 venereum, 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

Dr. Michael Casey, Dr. Jason Eckel, Dr. William Fan, Dr. James Godwin, Dr. Karn Gupta, Dr. Jeffrey Hoggard,
Dr. So Yoon Jang, Dr. Fred Jones, Dr. Dan Koenig, Dr. Kevin Lee, Dr. Sammy Moghazi,
Dr. Michael Monahan, Dr. Romita Mukerjee, Dr. Michael Oliverio, Dr. Robert Olivo, Dr. Sejan Patel, Dr. Eric Raasch,
Dr. Mark Rothman, Dr. Samsheer Sonawane, Dr. Adam Stern, Dr. Phillip Timmons