



**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

Dr. Michael Casey, Dr. Jason Eckel, Dr. William Fan, Dr. Raymond Geherty, Dr. Anwar Haidary, Dr. Akhil Hegde, Dr. Jeffrey Hoggard, Dr. Racquel Holmes, Dr. So Yoon Jang, Dr. Pankaj Jawa, Dr. Kevin Lee, Dr. Sammy Moghazi, Dr. Romita Mukerjee, Dr. Rushi Nayak, Dr. Michael Oliverio, Dr. Robert Olivo, Dr. Sejan Patel, Dr. Eric Raasch, Dr. Joseph Ruberwa, Dr. Laura Sims, Dr. Samsher Sonawane, Dr. Adam Stern, Dr. Kawan Swain, Dr. Phillip Timmons, Dr. Kyle Zoll