**SALEM FAMILY PRACTICE CLINIC, P.A.**
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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**Patient Information:**

Name: _____ DOB: _____/_____/_____
Address: Street_____ City: _____
State: _____ Zip: _____ Social Security #:_____-_____-_____

**I authorize to release my medical records to or from the following:**

Name or Facility: _____ Ph. #:_____
Address: _____ Fax #:_____

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**This Request and authorization applies to (check one):**

- ○ Healthcare information relating to the following treatment, condition or dates:

  _____
- ○ All healthcare information
- ○ Other: _____

_____

**Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included 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 any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient's Signature: _____ Date Signed: _____