AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize the release healthcare information of the patient named above

▣From ☐To

_____

_____

_____

Phone: _____

Fax: _____

☐From ☐To

East Valley Childrens Center

3200 S George Dr

Tempe AZ 85282

This request and authorization applies to:

☐ 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., 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 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.

I understand this authorization to release health records is voluntary and I may refuse to sign this authorization. Signing this authorization is not a condition of patient receiving treatment or payment for services, except as permitted by law. I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the patient or I am legally authorized as the patient's representative to execute this authorization and accept these terms.

_____ _____

Patient/Parent/Legal Guardian Signature **Date**

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED