



Plumtree Family Health Center

AUTHORIZATION FOR PLUMTREEE FAMILY HEALTH CENTER

TO OBTAIN HEALTHCARE INFORMATION FROM ANOTHER PARTY

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ Plumtree Family Health Center _____ to obtain healthcare information of the patient named above from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____(required)

This request and authorization applies to:

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

All healthcare information - # of years records _____

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 venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

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 Signature: _____ Date Signed: _____

This request is valid for 2 years after signed. Patient may revoke the authorization at any time. Requests to revoke this authorization may be made by phone or letter.