MID AMERICA
HEART & LUNG SURGEONS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

I request and authorize the release of my healthcare information to the following individual(s) (other than my attending physicians):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

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 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:_____

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