AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: *Available Upon Request*

I request and authorize _____ Fax #: _____

to release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Reason for request:

☐ Transfer ☐ Specialist ☐ Insurance ☐ Other: _____

This request and authorization applies to:

☐ All health care information

☐ Health care information relating to the following treatment, condition or dates: _____

_____

_____

☐ Other: _____

_____

This request includes or excludes the following:

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ 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.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes Herpes, Herpes Simpex, 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.

_____ _____

Signature of Patient or Parent/Guardian **Date**

Jeffrey A. Schiappa D.O.

10260 WEST 191st STREET MOKENA, ILLINOIS 60448 www.schiappadoc.com P: (708) 479-8889 F: (708) 479-8214