CAPITAL WOMEN'S CARE®

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name_____ Date of Birth_____

I request and authorize_____

to release healthcare information of the patient named above to:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

This request and authorization applies to:_____

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

_____

O All healthcare information:_____

O 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, lymphogranulomna venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

O Yes O 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.

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

Patient Signature:_____ Date Signed:_____

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my request. There is a minimum $10.00 office fee as set forth by Virginia's Health Records Privacy statue. These fees must be paid in full before your records are released. Please allow two weeks for processing.