



3300 Chambers Rd, Suite 5238, Horseheads NY 14845  
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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to: *(to hand-carry, write "self")*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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 venereum, 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.

Yes  No The intent of this record release is for the transfer of my medical care to another primary care provider. (Note: If you intend to transfer to another PCP, your electronic medical record will be marked as inactive. Your records will remain in our database, however you will be removed from future correspondence from our facility. This may be reversed at any time.)

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES \_\_\_\_/\_\_\_\_/\_\_\_\_ (IN NINETY DAYS IF LEFT BLANK)

**FOR USE BY OFFICE PERSONNEL ONLY**

PREPARED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

COMMENTS: \_\_\_\_\_