Masonboro Family Medicine, P.C.

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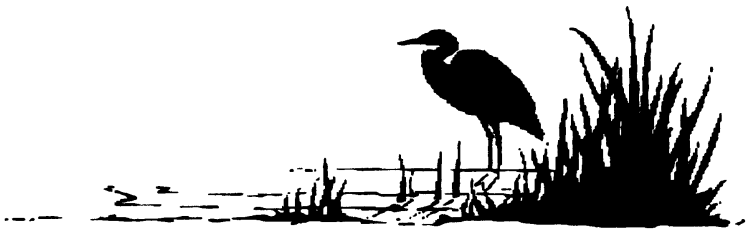

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____
to release healthcare information of the patient named above to: _____

This request and authorization applies to:

___Labs ___Last CPE ____ Last OV ____EKG ____CXR ____All 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 venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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.

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This authorization expires one year after it is signed.

Patient Signature:_____ Date signed: _____

Print Name: _____

Witness Signature: _____ Date signed: _____

Print Name: _____