Masonboro Family Medicine, P.C.

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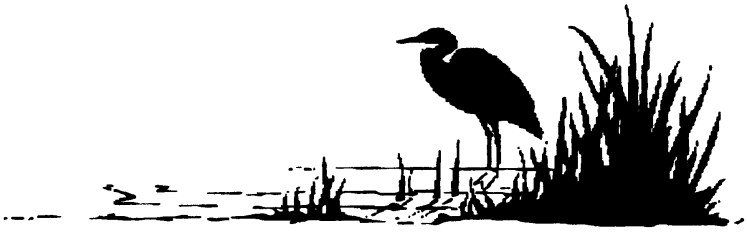

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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:

○ Healthcare information relating to the following treatment, condition, or dates

___Labs ___Last CPE ____ Last OV ____EKG ____CXR ____All records_____

____Other: _____

○ 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.

Definition: Alcohol and/or drug treatment is protected by the federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and their implementing regulations. *See generally 42C.F.R. Part 2; 45 C.F.R. Parts 160, 164.* I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal Law governing confidentiality of alcohol and drug abuse patient information noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug

○ Yes ○ No

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: _____