Board Certified Internal Medicine
Tanir Medical Center P.C.
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Authorization to Release Healthcare Information

Patient's Name

_____ _____ _____

(Last) (Middle) (First)

Date of Birth: _____/_____/_____ Social Security Number: _____

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

Name: _____ Date of Birth: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

The request and authorization applies to:

( ) Healthcare information relating to the following treatment (s), condition (s), and/or date (s): _____

_____

( ) All Healthcare information (s)

( ) Other (s): _____

Definition: Sexually Transmitted Disease (STD) as defined by the 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, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and gonorrhea.

( ) Yes ( ) No I authorize the release of my STD results, HIV/AIDS testing, whether positive or negative, to the person (s) and/or entities listed above. I understand that the person (s) and/or entities 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, and/or mental health treatment to the person (s) or entities listed above.

Patient Signature: _____

Patient's Date of Birth: _____/_____/_____

Date Signed: _____/_____/_____

This Authorization Expires Ninety Days After It Is Signed