The Purcell Clinic

Patients 18 years or Older Authorization to Release Healthcare Information

To Parent / Care Giver

Patient's Name: _____ Date of Birth: _____

Social Security # _____

I request and authorize _____The Purcell Clinic_____ to release healthcare information of the patient named above to Parent/ Care Giver:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

- ❑ All healthcare information including Lab results, and Diagnostic Imaging.
- ❑ Other: _____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, warts, genital warts, 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, Pregnancy 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.

Patient Signature: _____ Date Signed: _____

Financial Responsibility/ Billing Statements should be sent to:

Name: _____ Relationship: _____