

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

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

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

I request and authorize:

**Dr. Kristin van Konynenburg, MD**  
Whole Family Health Care  
600 S. Airport Road, Suite A-203, Longmont, CO 80503  
Phone: (303)776-0467 Fax: (303)776-0387

\_\_\_\_\_ To RELEASE information described to:

\_\_\_\_\_ To OBTAIN information described from:

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

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

\_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

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.

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Relationship to patient, if applicable: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.