Family Practice Associates

Records Release Authorization

Patient's Name: Date of Birth:

Previous Name: Social Security #:

Patient Address:

I request and authorize Family Practice Assocs of Exton & Marshallton to release healthcare information of the patient named above to the following

Doctor or Hospital:

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 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.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: _____ Date Signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.