AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____

Previous Name: _____Phone Number: _____

I request and authorize:

Dr. Kristin Van Konynenburg, MD
Whole Family Health Care, PLLC
1067 S. Hover St. Unit E-189
Longmont, CO 80501

_____ To RELEASE information described to:

_____ To OBTAIN information described from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

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, TCW 7.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS, 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.