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.