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HEARTLAND FAMILY FIRST MEDICAL CLINIC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: Date of Birth:

Previous Name: Social Security #:

Address: City:

State: Phone#:

____ I authorize the release of my medical records from the medical office listed below.

____ I authorize Heartland Family First Medical Clinic to release my records to the party listed below for the covered period of _____ to _____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

_____

○ All healthcare information ◉ Other

PLEASE SEND PAPER COPIES OF RECORDS – NO CD'S – EXCEPT RADIOLOGY IMAGES

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.

Patient/Guardian Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.