AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization grants permission for the party (parties) named below to: have access to medical information, laboratory results, test findings, and telephone communication; pick up medications, referrals, and notes; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial information. Also included is an authorization to leave similar medical information on a private phone or voice messaging system

I understand this authorization is voluntary.

Patient's Name: _____ Date of Birth: _____

I request and authorize Rocky Run Family Medicine
to release healthcare information of the patient named above as follows:

Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____
Private number / voicemail on which messages may be left: _____

☐ Check here if you do not authorize anyone else to have access to your information or have any number on record for leaving detailed messages

I understand that this authorization will (check 1):
- ☐ Expire 1 year from the date signed by the patient
- ☐ Be effective for the lifetime of the patient unless revoked in writing
- ☐ Be effective until _____

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates:_____

☐ All healthcare information (except as noted below)

☐ 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) or number listed above.

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

Patient Signature: _____ Date: _____