Behavioral Health Care, P.C.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	
I request and authorize			
to release healthcare information of the patient named above to:			
Name:			
Address:			
City:		State:	Zip Code:
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 Signature:		Date Signed:	

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.