duvall
advanced
family eyecare

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: Date of Birth:		
Previous Name:		
I request and authorize my health care information: ☐ TO ☐ FROM Duvall Advanced Family Eyecare		
☐ TO ☐ FROM Name:		
Address:		
City:	State:	ZIP Code:
PH#	FAX#	
This request and authorization applies to:		
☐ Health care information relating to the following treatment, condition, or dates:		
☐ All health care 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 Signature: Date Signed:		
POA/Guarantor Signature: Date Signed:		
POA/Guarantor Relationship:		

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.