REIS PEDIATRICS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(IS ANYONE OTHER THAN YOU AUTHORIZED TO REQUEST YOUR HEALTH INFORMATION-SUCH AS A FRIEND OR FAMILY MEMBER)

Patient's Name: ____________________________________ Date of Birth: ________________

Previous name (if applicable): ____

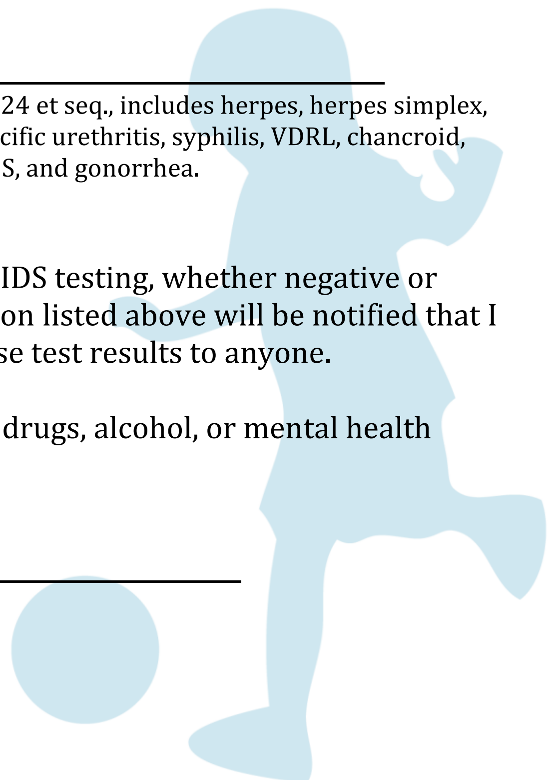
I request and authorize REIS PEDIATRICS to release my healthcare information to (for example, if you want your parent or guardian to have access to your records or be able to call our office on your behalf, list their name below):

Name: ____
Address: ____
City: ______________________ State: ________________ Zip Code: ___________________
Relation: __________________________ Phone number: _____________________________

This request and authorization applies to (check one please):

- ☐ Healthcare information relation to the following treatment, condition, 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, and gonorrhea.



*** Please circle one:**

YES NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person 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 drugs, alcohol, or mental health treatment to the person listed above.

Patient Signature: ________________________________ **Date:** __________________