AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________ Date of Birth: ________________________

Phone: ________________________ 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 understand this release may include any records regarding, STD, drug, alcohol, or mental health treatment to the person(s) listed above. I have read and understand this authorization and authorize the disclosure of the health information noted above.

I agree that a copy of this release or a fax of this release shall be as valid as this original. I understand that I may withdraw this authorization at any time by submitting such request in writing to Mecklenburg Neurological Associates (MNA). The request to revoke the authorization does not affect any health information disclosed prior to MNA receiving the written request. I release MNA and any and all employees from all liabilities, responsibilities, damages, losses and claims which might arise from the release of authorized information. Please send copies of all requested information to the address or fax number above.

Patient/Guardian
Signature: ______________________________ Date : ______________________________

MNA Signature: ______________________________ Date Released:______________________________

Method records were released. Fax___________________ Mailed___________ In Person_______________

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.

SUBMIT FORM