Bellevue Neurology

Roopa Bhat, MD, PhD
2020 NE 116th Ave, Suite 100
Bellevue, WA 98004

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ Phone: _____ Fax: _____
to release healthcare information of the patient named above to:

Name: Bellevue Neurology: Roopa Bhat, MD

Address: 2020 NE 116th Ave, Suite 100 Phone: (425)786-0080 Fax: (425)679-6005

City: Bellevue State: WA Zip Code: 98004

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, 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: _____

THIS AUTHORIZATION EXPIRES 90 (NINETY) DAYS AFTER IT IS SIGNED.