



Leon Springs Pediatrics

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

DOB: _____

I request and authorize **Leon Springs Pediatrics** to release healthcare information of the patient named above to:

Physician/ Health Facility/ Other: _____

Address: _____

City: _____

State: _____

Zip Code _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or date(s): _____
- 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, VORL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. understand that the person(s) listed above will be notified that must give specific written permission before disclosure of these test results to anyone.

Yes No authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Parent/Legal Guardian Signature: _____ Date Signed: _____

Relationship to patient: _____

THIS AUTHORIZATION WILL EXPIRE UPON THE RELEASE OF THE INFORMATION OR 90 DAYS (THREE MONTHS) FROM THE DATE OF THE SIGNATURE, WHICHEVER OCCURS FIRST
THE PATIENT CAN REVOKE THIS AUTHORIZATION IN WRITING AT ANYTIME PRIOR TO THE EXPIRATION DATE.