Leon Springs Pediatrics

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: DOB:

I request and authorize ______________________ ______________ ______________ to release
Facility/ Healthcare Facility Phone Number Fax Number

healthcare information of the patient named above to:

Leon Spring Pediatrics
7903 Calle Rialto
San Antonio, TX 78257

This request and authorization applies to:

O Healthcare information relating to the following treatment, condition, or date(s): ______________

O All healthcare information

O 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.

O Yes O 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.

O Yes O No I 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.