RECORDS REQUEST

PLEASE FAX RECORDS TO 904-648-6440

Patient Name: ____________________________Date of Birth: __________________________________

Previous Name: ____SSN #: _______________________

Patient Address: ____Phone #: _______________________

Reason for Request: ____

<u>This request and authorization applies to</u>:

☐ All health care information (documents, files, photos, etc.)

☐ Operative reports only

☐ Health care information relating to the following treatment, condition or dates: _________________

☐ 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. **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, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea

☐ 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: __________________

Revised & approved: 2021