

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:

Date of Birth:

Previous Name:

Social Security #:

I request and authorize PREMIUM UNITED CARE LLC to release healthcare information of the patient named above to:

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), A.IDS (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 NINETY DAYS AFTER IT IS SIGNED.