Weston Primary Care
56 Colpitts Rd
Weston, MA 02493
PH: 781-891-0906
F: 781-891-0912

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date of Birth: _____

Previous Name: _____Social Security #_____

I request and authorize _____ to Release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 urthritis, syphilis, gonorrhea VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), and AIDS (Acquired Immunodeficiency Syndrome).

☐ 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:_____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED