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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name:

I request and authorize **Lemon Tree Family Medicine, LLC** to release healthcare information of the patient named above to:

ARETE FAMILY CARE

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 venereum, HIV (Human Immunodeficiency Virus), AIDS (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, UNLESS OTHERWISE SPECIFIED.

Start Date **End Date**