

5045 RT 130 S, STE I Delran, NJ 08075 400 Creek Crossing Blvd. Suite 412, Hainesport, NJ 08036

Phone: 856-764-7660 Fax: 609-261-4893

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION/ THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
|  |  | Phone #/Fax # |  |
| I request and authorize |  | to |
| release healthcare information of the patient named above to: |
|  | Name:  |  |
|  | Address: |  |
|  | City: |  | State: |  | Zip Code: |  |
| 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), 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: |  |