Phone: 210-878-0090 Fax: 210-878-0037

545 Creekside Crossing, Suite 302
New Braunfels, Texas 78130

12413 Judson Rd., Suite 250
San Antonio, Texas 78233

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:

Previous Name: _____ Social Security #:

I request and authorize

Address: _____ Phone: _____

to release healthcare information of the patient named above to:

Name: Dr. Susan A. Crockett _____ Address:

City: __ State:

Texas _____ Zip Code:

Phone: 210-878-0090 Fax: 210-878-0037 Email: drcrockett@virtuosagyn.com

This request and authorization applies to:

□ Healthcare inform ation relating to the following treatment, condition, or dates:

□ All healthcare information

□ Other:

Definition: Sexually Transmitted Disease (STD), includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chacroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodefiencey 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.