

LANCE E. GRAVELY, M.D. INC.

NEUROLOGICAL SURGERY AND SPINE SURGERY

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 Code:
This request and authorization applies to:			
Healthcare information relating to the following treatment, condition, or dates:			
All healthcare information			
Other:			
<p>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.</p>			
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.			