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VIRTUOSA GYN

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: Virtuosa Gyn

Address: 12602 Toepperwein Road #208

City: Live Oak State: TX Zip Code: 78233

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

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), 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.