

REYNOSO MD
Medical Center LLC

Authorization to Release Healthcare Information

Patient Name(Print) _____ Date of Birth _____

Previous Name (if any) _____ Social Security Number _____

Records to be released FROM:

Facility/Doctor Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

Records to be released TO:

REYNOSO MD Medical Center, LLC
8595 East Bell Road, Suite 103
Scottsdale, Arizona 85260

This request and authorization applies to:

ALL healthcare information

Healthcare information relating to the following treatment, condition and/or dates:

Other: _____

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.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papiloma virus, wart, genital wart, condyloma, Chlamydia, non-specific vaginitis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

Yes No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Name (Print) _____

Patient Signature _____ **Date** _____