

Authorization To Release Healthcare Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name (if any): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**I request and authorize:** Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Release healthcare information of the patient named above to:**

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

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 papiloma virus, wart, genital wart, condyloma, Chlamydia, non-specific arthritis, 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:** \_\_\_\_\_

**8595 East Bell Road, Suite 103 Scottsdale, Arizona 85260 Phone: 480-659-1509 Fax: 480-659-0275**