ST. AUGUSTINE PEDIATRIC ASSOCIATES, PA

493 Prosperity Lake Drive * St. Augustine, FL 32092 * Phone: (904) 824-5437 Fax: (904) 824-7575

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

to release healthcare information of the patient named above to:

Name: ST. AUGUSTINE PEDIATRIC ASSOCIATES, P.A.

Address: 493 Prosperity Lake Drive

City: Saint Augustine State: FL Zip Code: 32092

Phone: (904) 824-KIDS Fax: (904) 824-7575

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 papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, 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/Parent Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.