

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

## **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Na	ame:	Date of Birth:					
Previous Na	ame:		Social Security #:				
I request and authorize							
	Address:						
(	City:		State:		Zip Code:		
	Phone:		Fax:				
to release healthcare information of the patient named above to:							
	Name:	ne: 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) 824-75	575		
This request and authorization applies to:							
☐ Healthcare information relating to the following treatment, condition, or dates:							
All healthcare information							
☐ Other:							
<b>Definition:</b> 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 ☐		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 ☐		authorize the release of any records regarding drug, alcohol, or mental health treatment to he person(s) listed above.					
Patient/Parent Signature:		Date Signed:					