AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

1011 Care Way Suite 200
Fredericksburg, VA 22401
(540)373-4900 Fax: (540)373-5195
H. Joon Kil, M.D., F.A.C.O.G
Heather Porto, CNM

Patient's Name:_____ Date of Birth:_____

Previous Name: _____SS#_____Ph#_____

I request and authorize_____ph #_____fax #_____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone:_____ Fax: _____

This request and authorization applies to:

_Healthcare information relating to the following treatment, condition:_____
Dates From_____ TO_____
_ All healthcare information
_ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 780.24 et seq., includes herpes, herpes simplex, Human Papilloma Virus, Wart, Genital wart, Condyloma, Chlamydia, non-specific urethritus, 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 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
Providing Patients Charts=$10 Service Fee plus .50 cents per page for the first 50 pages, .25 cents after 50 pages