OB ☐
GYN ☐

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

4541 Spotsylvania Parkway
Fredericksburg, VA 22408
(540)373-4900 Fax: (540)373-5195

Patient's Name:____ Date of Birth:________________________

Previous Name: ______________________________________SS#____________________Ph#__________________

I request and authorize **CENTRAL VIRGINIA OB/GYN GROUP, PC**, phone #540-373-4900 fax #540-373-5195 to release healthcare information of the patient named above to:

Name: ____ **PATIENT USB PICKUP** ☐

Address: ____ **PROVIDER SECURE FAX** ☐

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 (90) DAYS AFTER IT IS SIGNED

RECORDS TRANSFERRED **PROVIDER FAX** ☐

☐ **Non-encrypted USB drive- hand delivered to patient**

Patient Signature of Receipt ____ **Date:** _____________________