

507 Hospital Way, PO Box 577 Brewster, WA 98812 (509) 689-3749

THREE RIVERS FAMILY MEDICINE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patien	t Name:			Date of Birth:
Previous Name:				Social Security:
l reque inform	est and a	authoriz f the pat	e ient na	med above to: to release healthcare
		٠		THREE RIVERS FAMILY MEDICINE PO BOX 577 BREWSTER, WA 98812 PHONE: (509) 689-3749 FAX: (509) 689-9106
The re	equest and authorization applies to: Healthcare information relating to the following treatment, condition, or dates:			
	All healthcare information Other:			
humar	n papillo ogranulo	ma viru	s, wart	ed Disease (STD) as defined by law, RCW 70.24 et sq., includes herpes, herpes simplex, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, n, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), an
	Yes		No	I authorize the release of my SID 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 Signed:

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