THREE RIVERS
FAMILY MEDICINE

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

THREE RIVERS FAMILY MEDICINE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize _____ to release healthcare information of the patient named above to:

THREE RIVERS FAMILY MEDICINE
PO BOX 577
BREWSTER, WA 98812
PHONE: (509) 689-3749
FAX: (509) 689-9106

The request and authorization applies to: ☐ Transferring Care

☐ 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 sq., includes herpes, herpes simplex, human papilloma virus, wart genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venerueum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ 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. 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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED