FallbrookMedicalCenter
BECAUSE YOUR HEALTH MATTERS

Office 760-723-5900
593 East Elder Street, Suite B
Fallbrook Ca 92028

Authorization to Release Healthcare Information

Patient's Name:_____Date of Birth: _____

Previous Name:_____**Social Security:** _____

I request and authorize_____ to

Release healthcare information of the patient named above to:

FALLBROOK MEDICAL CENTER

593 E **Elder St Suite** B **Fallbrook, CA 92028**

Phone:760-723-5900

Fax: 760-723-5906

This request and authorization applies to:

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 seq. Includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific arthritis, syphilis, VDRL chancroid, lymphogranuloma venereuem, HIV(Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes Not 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 Not 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.