4435 Ronald Reagan Boulevard, Johnstown, CO 80534
Phone: (970) 619-8139 Fax: (970) 612-8013

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize **Thompson River Pediatrics** to release healthcare information of the patient named above to:

Office Name: _____
Phone: _____ Fax: _____
Address: _____

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates: _____
- ☐ All healthcare information
- ☐ Other: _____

Describe the purpose of the request:

- ☐ Patient Request
- ☐ Continued Care
- ☐ Attorney
- ☐ Finance
- ☐ 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 urethritis, 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 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.

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken.

Patient/Parent/Guardian Signature: _____ Date Signed: _____

Phone #: _____