Mountaineer Medical Services, PLLC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

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

Name:

This request and authorization applies to :

- ○ Healthcare information relating to the following treatment, condition, or dates:

  _____

  _____

  _____

- ○ All healthcare information
- ○ Other: Last 2 visits, last labs, problem list, medication list, x-rays, consultations

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymph granuloma 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 understand that my records are protected under Federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2) and Health Information Portability and Accountability Act (HIPPA), 45 CFR Pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event **this consent expires automatically in 90 days**.

I understand that I might be denied services if I refuse to consent to disclosure for the purpose if treatment, payment or health care options, if permitted by State Law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Patient signature: _____ Date:_____