WEST ORANGE NEPHROLOGY
Attaining wellness...Limiting the use of medications

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # _____

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

Name: _____

Address: _____

City: _____ St: _____ Zip Code: _____

Phone: _____ Fax: _____

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 urethritis, syphilis, VDRL. Chancroid, lymphogranuloma veneruem, 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.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINTEY DAYS AFTER IT IS SIGNED