Trivas
Family Medicine
Dr. Courtney Johnson MD 360-440-8376
3623 SW Alaska St Seattle, WA 98126 trivasfamilymedicine.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date of Birth: _____

Previous Name: _____

Requesting Records From: _____

_____

Releasing Records To:

❒Trivas Family Medicine, Dr. Courtney Johnson
3623 SW Alaska St, Seattle, WA 98116
Phone 360-440-8376, Fax 360-474-3947

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

❒All healthcare information

❒Healthcare information relating to the following treatment, condition, or dates: _____

_____

❒Other:_____

Definition:

Sexually Transmitted Disease (STD) as defined by law, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, 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.

Signature: _____

Printed name:_____
(Patient, guardian, or authorized representative)

Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.