

Austin's Friendly Family Medicine, P.A.

7600 Burnet Road, Suite 270 Austin, TX 78757 Tel: 512/377-AFFM (2336) Fax: 512/323-5256

AUTHORIZATION/REQUEST TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize (*Enter names of previous doctors, hospitals and/or clinics*):

_____ to release health care information of the patient named above to:

Austin's Friendly Family Medicine, PA - Jennifer A. Arnecilla, MD
7600 Burnet Road Suite 270 Austin, TX 78757-1246
T: 512-377-2336 F: 512-323-5256

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates:

 All health care 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 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.

Patient Signature: _____ Date Signed: _____