



## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release healthcare

information of the above named patient to:

Name: Dr. Chris Sudduth, Dr. Kaitlin Saucer, Dr. Jason Macias, Sarah Hart, APRN

Address: 3315 S Elm Pl. Broken Arrow, OK 74012

Phone: (918) 509-3990 Fax: (918) 238-6614

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 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: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Member: Email completed release to [sandradietz@remedyhealth.care](mailto:sandradietz@remedyhealth.care)