Summit Urgent Care Clinic

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		**Patient's Date of Birth:**	
Social Security:		**Name of Parent or Legal Guardian:**	

I authorize Summit Urgent Care Center to release my healthcare information to the person listed below:
(List below the person or Physician you would allow us to release your healthcare information to)

Name:				Relation to patient:	
Address:					
City/State:		Zip code:		Phone Number:	

This authorization applies to: (mark the one that applies)

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

☐ All healthcare information (ALL CHART NOTES, LABS, X-RAY REPORT, ETC...)

☐ Other:

☐ NO, I DO NOT ALLOW THE RELEASE OF MY MEDICAL RECORDS TO ANY INDIVIDUAL.

*******IF THE INFORMATION BELOW DOES NOT PERTAIN TO YOU, LEAVE IT BLANK.**

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 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.

Patient/Parent Signature:		**Date Signed:**	

I understand that I may revoke this consent in writing at any time, except when the information has already been released. THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.