Authorization for Release of Healthcare Information

Patient Name: _____ **Date of Birth:** _____/_____/_____

Previous Name (if any): _____ **Social Security Number:** _____-____-_____

If Minor, Guardian's Name/Relationship: _____

I request and authorize: _____

(Name of office requesting records from)

To release healthcare information regarding the above named patient to:

PrimeMed/Neurotech, Inc.
930 Kingsley Avenue, Orange Park, FL 32073
2511 St. John's Bluff Road South, #201, Jacksonville, FL 32246
Ph(904)269-0500/Fax(904)269-9805

This request and authorization applies to the following:

____ All Healthcare Information

____ Healthcare information relating to the following treatment, condition, and/or dates:
_____

____ Other: _____

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 st seq., include herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, nonspecific 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 Signature: _____ **Date:** _____