Bullock

OB/GYN & Med Spa

Emily Bullock, MD, FACOG

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and Authorize Dr. Emily Bullock, OB/GYN to release healthcare information of the patient named above to:

Doctor's Name: _____

Address:_____ Phone: _____ FAX: _____

This request and authorization applies to: Healthcare Information:_____

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.

_____ 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

_____ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listen above.

Patient Signature: _____ Date:_____