ACADEMIC UROLOGY & UROGYNECOLOGY OF ARIZONA

Phone 623-547-2600 / Fax 623-547-1899

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 patient named above to:

Name: Academic Urology & Urogynecology of Arizona

Address: 14044 W Camelback Rd. Suite 118

City: Litchfield Park , Arizona 85340

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 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 Signed: _____

THIS AUTHORIZATION EXPIRES **ONE YEAR** AFTER IT IS SIGNED.