Cosmas Primary Care, P.S.
2115 S. 56th Street, Ste 103
Tacoma, WA, 98409
(253) 345-4310 Phone
(253) 345-4370 Fax

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________________________Date of Birth: ______________________

Previous Name: ______________________________________

Requesting Records From: ____
____

Releasing Records To: ❒ Roxanne Ho, M.D.

✪✪

I request and authorize the release of the following healthcare information of the above named patient:

❒ All healthcare information

❒ Healthcare information relating to the following treatment, condition, or dates: ______________________
____

❒ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, 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.

Signature: ____

Printed name:____
(Patient, guardian, or authorized representative)

Date: ____________________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.