AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient's Name:_____ **Date of Birth:**_____

Previous Name:_____**SSN:**_____

I request and authorize _____

_____

to release protected healthcare information of the patient named above to:

Coddington Medical Family Practice, LLC
1336 West A St, Suite A
Lincoln, NE 68522

Please Fax to: 402-817-1245

This request and authorization applies to:

1. All protected healthcare information for the last two (2) years

2. Healthcare information relating to the following treatment, condition, or dates:_____

3. All healthcare information

4. 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.

(Circle One)

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 NINETY (90) DAYS AFTER IT IS SIGNED