Smith facial plastics

Stephen P. Smith, Jr., M.D

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize Stephen P. Smith, Jr,. M.D to release healthcare information of the patient named above to:

_____

_____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ○ Other

[List here] _____

[Additional 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.

○ Yes ○ No I authorize the release of my HEALTHCARE RECORDs, and **if applicable**, any 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 UNDERSTAND THAT THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Patient Signature: _____ Date signed: _____