Gros Ventre OB/GYN, LLP

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient's Full Name:_____

Date of Birth:_____ Maiden Name and/or Alias:_____

I request and authorize ***Gros Ventre OB/GYN, LLP*** to release healthcare information to the following individual(s):

Name: _____
Address: _____
Contact Number: _____ Relationship to Patient: _____

The request and authorization applies to:

☐ **Healthcare information relating to the following treatment, condition, or dates:** _____
_____

☐ **All healthcare information**

☐ **Other:** _____

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

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 venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

I hereby consent to the release of the above information. I release ***Gros Ventre OB/GYN, LLP*** and my attending physicians (s) from all liability and all claims of any nature whatsoever pertaining to disclosure of information concerning the above named individual.

_____ _____
Patient Signature Date

This authorization is valid for twelve (12) months unless revoked earlier in writing.

A photocopy of this authorization shall be considered as valid as the original.