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|  | M. Dawn Linn, DO |

109 Hazel Path, Ste 7, Hendersonville, TN 37075

Phone: 615-338-5750 | Fax: 615-447-3827 | www.raphafamilywellness.com

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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| Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other Name, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Social Security #: \_\_\_\_-\_\_\_-\_\_\_\_ |
| I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  to release healthcare information of the patient named above to: **RAPHA FAMILY WELLNESS, fax 615-447-3827** |  |

This request and authorization applies to:





**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.

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

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| Patient/Guardian Signature: |  | Date signed: |

### THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.