BioIntelligent Wellness

124 Lomas Santa Fe Drive Suite 206
Solana Beach, CA 92075
Phone: 858-228-3644 Fax: 760-994-1248

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

Previous Name: _____ **Social Security #:** _____

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

Name: **BioIntelligent Wellness**

Address: **124 Lomas Santa Fe Drive Suite 206**

City: **Solana Beach** **State:** **CA** **Zip Code:** **92075**

This request and authorization applies to:

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

_____

☐ All healthcare information

☐ 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.

☐ 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 DAYS AFTER IT IS SIGNED.