



MEDICAL RECORDS REQUEST

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Date Of Birth _____

Previous Name: _____ Social Security No: _____

I request and authorize **LIFEBOAT MEDICAL ASSOCIATES** to **RECEIVE** health care information of the patient named above **FROM**:

PREVIOUS PRIMARY PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- Health care information relating to the following treatment, condition, or dates:

- All health care information

- Other _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., Includes 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