



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name _____ Date of Birth _____

Previous Name _____ Social Security # _____

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

NAME: Vipul Parikh

ADDRESS: 15195 Heathcote Blvd. Suite 330

CITY: Haymarket STATE: VA ZIP CODE: 20169

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, non-specific urethritis, syphilis, VDRL, Chancroid, lymphogranuloma venereum, 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.