Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____ Date of Birth: _________

Address: ____

____

I hereby authorize: ____

____

To release my records to:

Ismary O. De Castro, MD
Savannah Endocrinology, LLC
107 Southern Blvd,, Suite 103, Savannah, GA 31405
Tel: (912) 232-5900 Fax: (912) 244-6744

For the purpose of: ____

This request and authorization apply to:

______Healthcare information relating to the following treatment, condition, or dates: ____________________

______ All healthcare information

______ Other (specify): ____

Definition: Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq, including herpes simplex, human papilloma virus, wart, genital warts, Condyloma, Chlamydia, non-specific urethritis, VDRL, chancroid, Lymphogranuloma venereum, HIV, AIDS, and gonorrhea

___Yes ___ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand the person 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 listed above.

This statement must be signed and dated and may be revoked at any time, except to the extend action has been taken prior to any expressed action to revoke this statement. The validity of this authorization will extend 30 days from the date of signature. If no action has been taken to process this statement within that time frame, an automatic expiration will be in effect. I understand the nature of this release and freely give my consent.

____ ________________

Authorized Signature Date

____ ________________

Witness Signature Date

The above name patient is unable to provide a signature. He/She understands the nature of this release and freely gives his/her consent.

____ ________________

Witness Signature Date