



University of Alabama in Huntsville • Wilson Hall Rm 325 • Huntsville, Alabama 35899 • Phone (256)824-6775 • Fax (256)824-6722

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient's Name: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

I request and authorize the release of my health care information as specified below:

**FROM** Name: UAHuntsville Student Health Center

Address: University of Alabama in Huntsville Wilson Hall Rm 325

City: Huntsville State: Alabama Zip Code: 35899

Phone: (256)824-6775 Fax: (256)824-6722

**TO** Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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, 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 individual or health care entity listed above.

**Patient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Witness**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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