Authorization to Release Health Care Information to UAH Health Clinic

Patient's Name: _____

Previous Name: _____

Date of Birth: _____

Contact Phone Number: _____

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

To:

Name: UAH Health Clinic

Address: University of Alabama in Huntsville, 301 Sparkman Drive, Wilson Hall 327

City: Huntsville State: Alabama Zip Code: 35899

Phone: (256) 824-6775 Fax: (256) 824-6722 or Immunizations@uah.edu

From:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Immunization Records Only

☐ 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