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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

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| --- | --- | --- | --- | --- |
| Patient’s Name: |  | | Date of Birth: |  |
| Previous Name (if applicable): | |  | Social Security #: |  |

|  |  |  |
| --- | --- | --- |
| I request and authorize |  | to release |

health care information of the patient named above to:

|  |  |
| --- | --- |
| Name: | PETER GRONDZIOWSKI, MD |

|  |  |
| --- | --- |
| Address: | PO BOX 14836 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: | PITTSBURGH | State: | PA | Zip Code: | 15234 |

This request and authorization applies to:

🞏 Healthcare information relating to the following treatment, condition, or dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 All healthcare information, including: 🞎 Electronic records 🞎 Paper records

🞎 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 venereum, HIV (Human Immunodficiency 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 tests 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.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Patient or Legally Authorized Representative: |  | Date Signed: |  |

|  |  |
| --- | --- |
| Printed Name of Legally Authorized Representative: |  |

Relationship to Patient: 🞎 Spouse 🞎 Parent 🞎 Next-of-Kin 🞎 Legal Guardian 🞎 Health DPOA

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED