Port Jeff Medical Care, P.C.
The Harbor of Good Health
410 Hallock Avenue
Port Jefferson Sta. NY 11776

PREVIOUS PHYSCIAN'S ADDRESS:

_____

_____

_____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____
Previous Name: _____ **Social Security #:** _____
I request and authorize _____ to release health care information of the patient named above to:

Port Jeff Medical Care, P.C.
410 Hallock Avenue
Port Jefferson Station, NY 11776

___ 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 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.