PO Box 850/ 24 E. Front Street, Suite 107
Pataskala, OH 43062
740- 777-9039 (p)/740-777-9041 (f)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________________________Date of Birth: ______________________

Previous (maiden) Name: ______________________________________

Requesting Records ❒ To ❒ From: ____

____

Releasing Records To: ❒ Ebunoluwa Wion DO (AffirmHD) ❒ Other: ____

✪✪

I request and authorize the release of the following healthcare information of the above named patient:

❒ All healthcare information

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

❒ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, 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.

Signature: ____

Printed name:____

(Circle one: Patient, parent, guardian, or authorized representative)

Date: ____________________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.