HUMBOLDT NEUROLOGICAL MEDICAL GROUP, INC.

Board Certifications in Clinical Neurology • Neurophysiological Testing • Sleep Medicine

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize **Humboldt Neurological Medical Group, Inc.** To release healthcare information of the patient named above to:

Name: ______________________

Address: ______________________

City: ______________________ State: __________ ZIP Code: __________

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: ______________________

Patient Representative: ______________________ Date Signed: ______________________

Representative's Authority: ______________________

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.