ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________________

Previous Name: ______________________________ Social Security #: ________________

I request and authorize:

Name: ____

Address: ____

City: _______________________ State: __________________ Zip code: ____________

Phone: _____________________ Fax: _____________________

To release healthcare information of the patient named above to:

Adult and Geriatric Center of South Florida
4399 Nob Hill Rd, Sunrise FL 33351
Phone: 954-799-6900 Fax: 954-827-3803

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:
  ____
- All healthcare 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.

O Yes O 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.

O Yes O No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) lIsted above

Patent Signature: _______________________________ Date: __________________________

This authorization expires 90 days after it is signed