AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security No.:_____

I request and authorize _____Virtuosa GYN_____

Address: _12602 Toepperwein Rd., Ste. 208, Live Oak, TX 78233 Phone: __210-878-0090__
to release healthcare information of the patient named above to:

Name: _____

Address:_____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

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), includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chacroid, lymphogranuloma venereuem, 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 treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.