

- S. BRENT BROTZMAN, M.D.
- ROBERT D. GRAHAM, II, M.D. Please check which doctor ☺
- CAMILLE M. BARTON, PA-C
- STEPHEN GRIFFIN, PA-C

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name _____ Date of Birth _____

Parent's Name _____ Social Security _____ - _____ - _____

I request and authorize _____ to release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zipcode : _____

office # _____ fax # _____

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 Diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, condyloma, cyamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea. Pregnancy Test Results, drug/alcohol, mental health information may also be included.

By signing below I am authorizing all my medical records, as disclosed and described above to be release.

SIGNATURE : _____ DATE : _____

Office use:
 Mailed/Picked Up _____ Initials _____