



# Medical Information

18 Elm Street, Topsham, Maine 04086  
Phone: (207) 729-4201 Fax: (207) 729-4453

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Previous Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

I request and authorize \_\_\_\_\_  
to release healthcare information of the patient named above to:

**Name:** \_\_\_\_\_

**Address** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

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 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: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.**