Center for Neurorehabilitation Services

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO **FAMILY/FRIENDS/SIGNIFICANT OTHERS**

PatientName:_____
Date of Birth:_____ Previous Name:_____

I request and authorize Center for Neurorehabilitation Services, P.C. to release healthcare information of the patient named above to: **List- First Name, Last Name and Relationship**

1. _____
2. _____
3. _____
4. _____

This request and authorization applies to:

[ ] Healthcare information relating to the following treatment, conditions, or dates:
_____

[ ] All Healthcare Information

[ ] Other Information _____

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, Chancroid, Lymphogranuloma venereum, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), 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 disclosing 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:_____

THIS AUTHORIZATION EXPIRES TWELVE MONTHS AFTER IT IS SIGNED

7401 Beaufont Springs Drive • Suite 205 • Richmond, VA 23225
(804) 272-0114 • Fax (804) 272-1125