Healthcare Discussion Authorization

Today's Date: _____

Client Information

Client Name: _____ DOB: _____

Previous Name: _____ SSN#: _____

☐ I request and authorize WellQuest Medical and Wellness to **discuss** healthcare information on the patient named above with:

Name: _____

Phone: _____

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 seg, includes Herpes Simplex, Human Papilloma Virus, Genital Warts, 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.

Conditions of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for one year for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from their office, directly.

I understand that information disclosed to parties other that health care providers, health plans, of health care clearinghouses may no longer be protected under federal privacy standards and that my health information may potentially be re-disclosed without obtaining my authorization.

Client Signature: _____ Date: _____

Request Received By: _____

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