Arizona Advanced Health Services

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Mesa, AZ 85269

Phone # 480-993-3710

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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
| Previous Name: |  | Social Security #: |  |
| I request and authorize | Dr Karami | to |
| release healthcare information of the patient named above to: |
|  | Name: |  |
|  | Name: |  |  |  |  |  |
|  | Name: |  |  |  |  |  |
|  | Name: |  |  |  |  |  |
|  | Name: |  |  |  |  |  |
| 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 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 health treatment to the person(s) listed above. |
| Patient Signature: |  | Date Signed: |  |
|  |
| THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED. |