GRETNA FAMILY HEALTH
Health . Wellness . Beauty

Medical Release Request

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

NAME - LAST	FIRST	MIDDLE	DOB	SS#

PREVIOUS NAME	PRIMARY PHONE

ADDRESS

CITY	STATE	ZIP CODE

FROM: I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM THE MEDICAL OFFICE BELOW:

NAME OF MEDICAL OFFICE	PHONE

STREET ADDRESS

CITY	STATE	ZIP CODE

TO: I AUTHORIZE GRETNA FAMILY HEALTH TO RELEASE MY MEDICAL RECORDS TO THE PERSON/MEDICAL OFFICE BELOW:

NAME OF MEDICAL OFFICE	PHONE

STREET 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 Diseases (STD), as defined by law, RCW 70.24 et seq., include Herpes, Herpes Simplex, Human Papilloma Virus (HPV), wartS, genital wart, Condyloma, Chlamydia, non-specific urethritis, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.