Tapadia EYE CARE

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Authorization to Release Healthcare Information for Patient's Own Personal Use

Patient's Name: _____

Date of birth: _____

I request and authorize Tapadia Eye Care
to release my healthcare information to myself for my own personal use.

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 myself.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to myself.

Signature of patient or legal guardian	Date	Time
Print name	Relationship to patient	

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.