Tapadia EYE CARE

1075 Yorba Place, Suite 205
Placentia, California 92870
714.912.7002
714.975.9822 *fax*
www.tapadiaeyecare.com

Authorization to Release Healthcare Information

Patient's Name: _____

Date of birth: _____

I request and authorize Tapadia Eye Care
to release healthcare information of the patient named above to:

Name: _____

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 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.

_____ _____ _____
Signature of patient or legal guardian Date Time

_____ _____
Print name Relationship to patient

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.