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 ______________________________
to release healthcare information of the patient named above to:

Name: Tapadia Eye Care

Address: 1075 Yorba Place, Suite 205

City: Placentia State: CA Zip Code: 92870

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________________

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☐ 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.