WESTCARE CLINIC

I, _____ hereby grant permission to and authorize the use or disclosure of the named individual's records as described below:

INFORMATION TO BE RELEASED:

□ The most recent 2 years of information (Chart notes, labs, x-rays and tests) excluding registration/billing information

□ All medical records excluding registration/billing information

□ Specific Information (Please specify by date(s)

_____

_____

RELEASE REQUIRING ADDITIONAL, SPECIFIC CONSENT:

I understand that my initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:

_____ (Initial) HIV/AIDS

_____ (Initial) Mental Health

_____ (Initial) Sexually Transmitted Diseases

_____ (Initial) Substance Abuse

_____ (Initial) Reproductive Care (minors only)

MINORS— A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____ _____ _____

Date Signature of patient or patient's representative Relationship to patient

□ Check if patient is a minor

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

_____

PHONE_____ _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

INFORMATION TO BE RELEASED TO:

(information will be released to this address)

NAME: _____
ORGANIZATION: _____

ADDRESS: _____

_____

PHONE: _____

PURPOSE OF DISCLOSURE: □ Continuing Care □ Legal □ Insurance □ Patient Request □ Other (explain)_____

_____ _____

Signature of patient or patient's representative Date