Alliance Medical Associates, PLLC
2905 Crouse Lane
Burlington, NC 27215

Phone: (336) 538-2494
Fax: (336) 538-2497

Release of Medical Information

(Complete this form to request information from a previous healthcare provider.)

Patient's Name: ____ Date of Birth: _________________________

Previous Name: _______________________________________ Social Security #: _______-________-________

I request and authorize----Doctor: ____

Facility: ____ Department: ___________________________________

Phone: __________________________________ Fax: _____________________________________

Address: *To release healthcare information of the patient named above, send to:*

Alliance Medical Associates, PLLC
2905 Crouse Lane
Burlington, NC 27215
Phone: (336) 538-2494 Fax: (336) 538-2497

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 Syndrom), 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.

____ _____________________________

Patient Signature **Date**

THIS AUTHORIZATION EXPIRES 90 (NINETY) DAYS AFTER IT IS SIGNED.

Revised 01/23/2012