NEW BEGINNINGS
Mental Health and Wellness

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________ Date of Birth: __________________________

Previous Name: ________________________ Social Security #: ________________________

I request and authorize ____ to release my healthcare information to
Doctor's Name/Clinic Name/Address

New Beginnings Mental Health and Wellness.

☐ Please check this box if you would like to authorize both people/organizations listed above to share authorized information.

This request and authorization applies to:

- ○ Healthcare information relating to the following treatment, condition, or dates:
  ____
  ____
- ○ All healthcare information
- ○ Other: ____

- ○ Yes – I authorize the release any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
- ○ No – I do NOT authorize the release any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definition: Sexually Transmitted Disease (STD) is 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, HHIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- ○ Yes – I authorize the release of my STD results, HIV/AIDS, 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.
- ○ No – I do NOT authorize the release of my STD results, HIV/AIDS, whether negative or positive, to the person(s) listed above.

__________________________________ __________________________________

Patient signature Date of Birth