



620 Dr. Calvin Jones Highway, Suite 212  
Wake Forest, NC 27587  
Phone: 919-761-5678  
Fax: 919-761-5680

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: Heritage Urgent & Primary Care

Address: 720 Dr. Calvin Jones Highway Suite 212

City: Wake Forest State: NC Zip Code: 27587

Phone: 919-761-5678 Fax: 919-761-5680

This request and authorization applies to all:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Purpose or Need for the Disclosure Is:

Continued Medical Care  Insurance  Legal  Patient's Own Use  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 venereum, 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.

**Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.