W.T.I.P
WEST TEXAS INJURY PREVENTION

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:

Patient's Name: _____ Date of Birth: _____

Other Names: _____ Social Security #: _____

Address: _____ Phone: _____

I request and authorize _____ to release healthcare information of the patient named above to: WTIP

Name: WEST TEXAS INJURY PREVENTION PHONE 432.264.1920

Address: 1111 SCURRY STREET FAX 432.264.1725

City: BIG SPRING State: TX Zip Code: 79720

This request and authorization applies to:

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

☐ All healthcare information: Lab Medication Xrays Progress notes Immunizations

☐ Other: _____

Purpose of Release: Continued care by other health care provider

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.

RELEASE FROM LIABILITY: I release and agree to hold harmless WTIP and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand WIP cannot be responsible for use or rediscover of information to third parties. If the services are being provided at the request of and being paid for by my employer or prospective employer, I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer (prospective). Additional information is noted in Notice of Privacy Practice.

☐ 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.

I certify that this form has been fully explained to me, have read it or had it read to me*, and understand its contents. _____

Patient Signature: _____ Date Signed: _____

Witness/Translator _____ Relationship: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.