Wellscape Direct MD
30 Lancaster Street, Suite 100
Boston, MA 02114

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ *(name)*

_____ *(phone and/or location)*

to release healthcare information of the patient named above to:

Wellscape Direct MD
30 Lancaster Street, Suite 100
Boston, MA 02114
Phone 617-918-7598
Fax 844-269-5508

For the purpose of: **clinical care**

This request and authorization applies to:

❑ All healthcare information

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

_____

❑ Other: _____

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

** **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.*

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

❑ Yes ❑ No

Patient Signature: _____ Date Signed: _____

This authorization expires ninety days after it is signed.