**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release healthcare information requested by:

**Agency Name: Western Mass Care Solutions, LLC**

This request and authorization apply to the following:

* Healthcare information relating to the specific care, treatment, conditions, or dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* All healthcare information, including diagnoses, lab test results, treatments, and billing records for all conditions.

Consent to release information expires one year from the date the Authorization is signed or upon termination of services with the enrolled agency. The Authorization remains valid until its expiration, revocation by the client in writing, in person, or by phone before the expiration date. The client may withdraw their authorization at any time except to the extent that action has already been taken.

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., including herpes, herpes simplex, human papillomavirus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, lymphogranuloma vereneuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

* **Yes**, I authorize the release of my STD results, and HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand the person(s) listed above will be notified that I must give specific written permission before disclosure of the test results is released to anyone.
* **No**, I do not authorize the release of my STD and HIV/AIDS testing results.
* **Partial**: ONLY release results for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_