



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

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

Name: CENTRAL MARYLAND ORAL AND MAXILLOFACIAL SURGERY, PA

Address: 10710 CHARTER DRIVE, STE 330 FAX 410-997-0807

City: COLUMBIA State: MD 21044

This request and authorization applies to:

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

All healthcare information

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.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.