ZealthCare Medical Clinic

Internal Medicine/Pediatrics

19121 West Little York, Suite B, Katy, TX 77449

Tel: (713) 955 5200 Email: contact@zealthcaremedicalclinic.com

Fax: (281) 858 1251 Website: www.zealthcaremedicalclinic.com

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: ZEALTHCARE MEDICAL CLINIC

Address: 19121 WEST LITTLE YORK , SUITE B

City: KATY State: TX Zip Code: 77449

Fax: **281-858-1251** **Phone :** **713-955-5200**

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 venereuem, 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: _____