7180 E. Orchard Rd. #306
Centennial, CO 80111
(720) 452-7420
info@cornerstonehealthcommunity.com
cornerstonehealthcommunity.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ *Date of Birth:* ______________ *Social Security #:* ______________

I request and authorize:

Cornerstone Health Community

7180 E. Orchard Rd. #306

Centennial, CO 80111

To release healthcare information of the patient named above to:

Name: ______________________ *Address:* ______________________

Phone: ______________________ *Fax:* ______________________

This request and authorization applies to:

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

____

List here:

○ All healthcare information ○ Other

List other:

____

Additional Information:

____

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.

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.

○ Yes ○ No

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

______________________________ ______________

Client Signature Date

______________________________ ______________

Parent/Legal Guardian Signature Date