

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth _____

I request and authorize:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

to release healthcare information of the patient named above to:

Name Boyce Hornberger, MD

Address 3151 N Alafaya Tr Ste 103

City Orlando State FL Zip Code 32826

Phone (407) 380-8700 Fax (407) 380-7043

This request and authorization applies to:

- All healthcare information
- Healthcare information relating to the following treatment, condition, or dates: _____

- Other: _____

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.

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

Patient's Signature (Parent if under 18) Date

Print Parent Name (if patient under 18)