ASHEWELL
MEDICAL GROUP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (and anypreviously used names): **Date of Birth:**

_____ _____

Social Security Number: _____

I request and authorize: _____
(former healthcare provider and office name)
to release healthcare information pertaining to the patient named above to:

Name: Dr. Carly Brown, MD, Dr. Anna Bartow, and Ashewell Medical Group
Address: 408 Depot Street, Suite 150
City: Asheville **State:** NC **Zip Code:** 28801

☐ 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

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.

Patient Signature: **Date:**

_____ _____

-For Office Use Only-:

This request and authorization applies to:

☐ All Healthcare information
☐ Immunizations ☐ Labs ☐ Two Most Recent Office Notes
☐ Imaging Results ☐ EKG ☐ Test Exam Results
☐ Other:

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