St. Gianna Clinic

Truly Excellent. Always Faithful.™

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Date of birth: _____

Address: _____

Phone: _____ Previous name: _____

I request and authorize: Bellin Health / HSHS St. Vincent / St. Mary/ ThedaCare / Ascension/Aurora

Other: _____ Address: _____ Fax _____
to release healthcare information of the patient named above to:

St. Gianna Clinic

1716 Lawrence Dr.
De Pere, WI 54115
phone: 920-605-3115
fax: 920-486-6826

This request and authorization applies to:

☐ All Health Care Information

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

_____

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.25 et seq., includes herpes, herpes simplex, human papillomavirus, 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.

I may revoke this consent to release medical information at any time by sending a written statement to St. Gianna Clinic.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED