St. Gianna Clinic
Truly Excellent. Always Faithful.™

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: ____ **PATIENT'S** Date of Birth: _______________

PATIENT'S ADDRESS: ____

Phone: _________________________________ **PATIENT'S** Previous Name: _____________________________

I request and authorize: ☐ Bellin Health ☐ HSHS St. Vincent ☐ St. Mary ☐ TedaCare ☐ Ascension

☐ Other: _______________________________Address: __________________ Fax: ____________________

to RELEASE healthcare information of the patient named above TO St. Gianna Clinic.

☐ Yes ☐ No
TO:
St. Gianna Clinic
1716 Lawrence Dr.
De Pere, WI 54115
Phone: (920) 605-3115
Fax: (920) 486-6826

OR

☐ Yes ☐ No – I authorize St. Gianna Clinic to **SEND** records
TO:
Other: ____
Address: ____
Phone: _________________________Fax: ____________________

This request and authorization applies to [MUST MARK AT LEAST ONE]:

☐ Yes ☐ No – **ALL** Healthcare Information

☐ Yes ☐ No – 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