Joanne Clinch, MD
Ann Potter, FNP-C
M. Abigail Barnes, FNP-C
Laura Santos, ATC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________ Date of Birth ________________________

Previous Name: ________________________ Social Security # ______________________

I request and authorize the **University of North Carolina School of the Arts Wellness Center** to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: _____________________ State _____________________ Zip Code _____________

This request and authorization applies to:
□ Healthcare information relating to the following treatment condition or dates: ______________

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□ All healthcare information

□ Other: ____

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 (Aquired 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 to the test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, mental health treatment to the person(s) listed above.

Patient Signature _______________________________ Date Signed _______________________

THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR AFTER IT IS SIGNED

Student Health Services
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