Life Center Family Medicine

Medical Record Request Form

Dr. Dana Simpson, MD
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Life Center Family Medicine (LCFM): Dr. Dana Simpson, Dr. Christian Hanley Jr, Mandy Walker LPC, and/or Claudia Hafer LPC

To send/receive healthcare information of the patient named above to:

Name: _____

Fax: _____

This request and authorization applies to:

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

_____

☐ All healthcare information (This may include records from other healthcare providers, patient history forms, insurance information, correspondence, etc. It is not strictly limited to records generated by the physician/provider listed above).

☐ 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 (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the LCFM staff. I understand that the LCFM staff will be notified that I must give specific written permission before disclosure of these test results to anyone outside our office.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the LCFM staff.

Patient Signature: Date Signed:

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Name Printed: _____ Relationship to Patient: _____