Grace Gulf Breeze LLC
3000 Gulf Breeze Parkway Suite 11, Gulf Breeze, FL 32563

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____

Date of Birth:_____

Previous Name:_____

Social Security #:_____

I request and authorize to release healthcare information of the patient named above to:

Physician's name: __Dr. Caroline Snowberger_____

Address: Grace Gulf Breeze LLC, 3000 Gulf Breeze Parkway, Gulf Breeze, FL 32563

Phone: _____

This request and authorization applies to:

[__] Healthcare information relating to the following treatment, condition, or dates:

[__] 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 (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.

Patient Signature: _____Date Signed:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.