Whitefoord, Inc.

WHITEFOORD FAMILY MEDICAL CENTER	WHITEFOORD SCHOOL BASED HEALTH CENTER	KING MIDDLE SCHOOL BASED HEALTH CENTER	TOOMER ELEMENTARY SCHOOL BASED HEALTH CENTER
30 Warren Street	35 WHITEFOORD AVE, SE	545 HILL ST. SE	65 ROGER ST NE
Atlanta, GA 30317	ATLANTA, GA 30317	ATLANTA, GA 30312	ATLANTA, GA 30317
Phone: (404) 373-2282	PHONE 404-588-0101	404-373-3530	PHONE 404-373-6614
Fax: (404) 373-2926	FAX: 404-588-0226	FAX 404- 373- 2926	FAX 404-373-2926

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____Date of Birth _____/_____/_____

Previous Name: _____Social Security#_____:_____:_____

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

_____

_____

_____

This request and authorization applies to:

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

_____

☐ **All healthcare information OR**

☐ **Records only**
☐ **Labs Results and X-ray/Radiology Reports**
☐ **Consultant Notes**

☐ **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, lymph granuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

☐ **Yes** ☐ **No I authorize the release of 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**

_____/_____/_____
Parent/Guardian Signature **Date**

_____
Print Name

----------◈**This Authorization Expires 180 Days After It Is Signed**◈----------