SOUTH POINTE MEDICAL

Authorization to Release Healthcare Information

Patient's Name____ DOB: ______________________

I request and authorize:

Doctors Name: ____

Address: ____

Phone: ____

To release healthcare information of the patient named about to:

South Pointe Medical
380 Empire Road Suite 120
Lafayette, CO 80026
PH: 303-665-8444
Fax: 303-665-8448

☐ Healthcare information relation to the following treatment, condition, or dates: ______________________

☐ All Healthcare Information

☐ Other: ____

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. ___________ INITIALS

Patient Signature:_______________________________________ Date Signed: _________________