Paul G. Hovsepian, M.D.
11 E. Adams Ave.
Alhambra, CA 91801

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Alternate Name: _____ Social Security #: _____-_____-_____
(If different from above)

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

Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

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 (HPV), wart, genital wart, condyloma, Chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), 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:_____