Life Savers EMERGENCY ROOM
Always Open . Always Ready

17685 TOMBALL PARKWAY
HOUSTON, TX 77064
PHN: 832-779-5433 FAX: 832-604-5433

3820 NORTH SHEPHERD DR. SUITE A.
HOUSTON, TX 77018
PHN: 281-766-8911 FAX: 832-742-9896

Patient Label

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Facility: Life Savers Emergency Room

Patient: _____

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

Doctor Office Name : _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ EXT: _____ Fax: _____

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.

☐ **I decline authorization to release healthcare information.**

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.