ADVOCATE MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Birth Date: _____

Previous Name: _____ Social Security: _____

I request and authorize my healthcare information to be Released to:

AdvocateMD - 417 Commmercial Court, Suite C, Venice, Florida 34292. Fax 941.220.0400

This request and authorization applied to:

☐ All Healthcare Information – Please include ONLY
2 years of office notes/consult notes, labs and diagnostic imaging

All Available Records for -

EKG or ECG
Colonoscopy
Mammogram
Bone Density/DEXA
Immunization Records
Ultrasound Results – ECHO/Carotid US/Lower Extremity US
Cervical Cancer Screening Results
Dilated Eye Exam

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

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, 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:_____

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS

NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE