Gregorio Santos, M.A., P.A.

6125 54th Ave N Suite B, Kenneth City, FL 33709
Phone: 727-521-9467 Fax: 727-521-0416

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to

Phone # _____ Fax# _____

release healthcare information of the patient named above to:

Name: Gregorio S Santos MD PA

Address: 6125 54th Ave N, Suite B

City: Kenneth City State: FL Zip Code: 33709

Phone: (727) 521-9467 Fax: (727) 521-0416

This request and authorization applies to:

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

_____

X All healthcare information (Last 5 years for New PCP)

☐ 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.

X 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.

X 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: _____