Print Form

NEWPORT Urgent CARE INC.

1000 Bristol Street North Suite 1B, Newport Beach, CA 92660
Tel: (949) 752.6300 Fax: (949) 752.6333

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____

Previous Name: _____ Social Security #: | | | | | | | | | |

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

Name: Newport Urgent Care

Address: 1000 Bristol Street North, 1B

City: Newport Beach State: CA Zip Code: 92660

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition or dates:

_____

☐ All health care information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results and/or 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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED