Rocky Creek Family Medicine

Deirdre McMullen M.D. Tiyashi Choudhury M.D. Hillary Spears FNP

3281 Rocky Creek Drive, Ste 500 Missouri City, TX 77459

Phone: 281-206-0068 Fax: 281-499-5045

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

Previous Name: _____ **Social Security #:** _____

I request and authorize: _____

_____ **Phone:** _____ **Fax:** _____

To release healthcare information of the patient to:

Deirdre McMullen M.D. Tiyashi Choudhury M.D. and/or Hillary Spears FNP
3281 Rock Creek Drive, Ste 500
Missouri City, TX 77459

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.

Patient/Guardian Signature:_____ **Date:** _____

Print Guardian Name, if applicable: _____ **Relationship:** _____

DEADLINE FOR RELEASE OF RECORDS: THE REQUESTED COPIES OF MEDICAL AND/OR BILLING RECORDS OR A SUMMARY OR NARRATIVE OF THE RECORDS SHALL BE FURNISHED BY THE PHYSICAIN WITHING 15 BUSINESS DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST AND REASONABLE FEES FOR FURNISHING THE INFORMATION.