

**JAMES C. WASSON, M.D., P.C.**  
534 SOUTH MAIN STREET  
NAZARETH, PA 18064  
610-746-1860  
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**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: James C Wasson, M.D., P.C.

Address: 534 South Main Street

City: Nazareth State: PA Zip Code: 18064

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, 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 Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

(By signing this document, I assume all financial responsibility for costs of reproduction of records.)

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.