JAMES C. WASSON, M.D., P.C.
534 SOUTH MAIN STREET
NAZARETH, PA 18064
610-746-1860
DRWASSON@DRWASSON.COM

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.