

BOARD CERTIFIED PHYSICIANS

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Albert G. Alessi, D.O. • Patricia A. Alessi, D.O.

Erin Brouillard, P.A.-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

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

Name: _____ Alessi Family Care
Address: 9400 Bonita Beach Rd. S.E. Ste. #102
Bonita Springs, FL 34135
City: 239-992-5444 State: _____ Zip Code: _____
Fax # 239-992-1315

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 venereum, 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: _____