QUEENS UNIVERSITY OF CHARLOTTE
1900 Selwyn Ave., Charlotte NC 28274
Phone: 704.337.2220 Fax: 704.337.2333

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name: _____

Date of Birth: _____ Previous Names: _____

I request and authorize Queens University of Charlotte Health and Wellness staff to disclose/release/exchange/obtain specified healthcare information from my Health and Wellness record to/with/from:

Name: _____

Address: _____

City: _____State:_____ Zip Code:_____

Fax Number: _____

This request and authorization applies to:

☐ Healthcare information relating to the following dates, treatment, and/or condition:
_____
_____

☐ All healthcare information

☐ Other: _____

☐ I understand that information to be disclosed/communicated/released/exchanged to/with/for each provider may be communicated in written, verbal, or electronic form

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-specified 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

☐**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: _____

Witness Signature_____Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED