

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

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

I request and authorize:
(Transfer FROM) _____ To
release healthcare information of the patient named above to (Transfer TO):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax*: _____ Email*: _____

*Please check box if you would like records faxed or emailed. By checking the box you are acknowledging that transfer of records via this method may not be as secure as through mail and release Datalink ITS Inc. of any liability. If you choose the email option, you will receive a link at the email address you specify which will redirect you to a secure server and allow you to securely download the requested information.

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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

PLEASE INCLUDE PROCESSING FEE OF \$25 WITH THIS AUTHORIZATION.

PAPER COPIES WILL INCUR AN ADDITIONAL FEE OF .10 CENTS PER PAGE PLUS POSTAGE. IF PAPER COPIES ARE REQUIRED YOU WILL RECEIVE AN INVOICE FOR THE BALANCE DUE ALONG WITH YOUR MEDICAL RECORDS. THIS IS IN ADDITION TO THE \$25 PRE PAYMENT.

PLEASE NOTE: IN COMPLIANCE WITH CA. HEALTH AND SAFETY CODE (123110) AND CA. EVIDENCE CODE (1158) DATALINK WILL CHARGE A FLAT RATE OF \$25 DUE WITH THIS AUTHORIZATION

