Quality Care Medicine, LLC
4407 6th. Street SW
Vero Beach. Fl. 32968
Phone: 772-907-5935 Fax: 772-217-2761

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize from Dr. _____ Phone: _____

Fax # _____ ***** If records exceed more than 10 pages please mail ****

To release healthcare information of the patient named above to:

Quality Care Medicine, LLC

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

Last 2 progress notes and Labs and Diagnostic tests

Definition: Sexual Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, chlamydia, and non-specific urethritis, VDRL, Chancroid, lymphogranuloma venereuem, HIV, Aids and gonorrhea.

Yes, No X
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 tests results to anyone.

Yes, No X
I authorize the release if any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Family/POA Signature: _____ Date Signed: _____