Smith facial plastics

Stephen P. Smith, Jr., M.D
Scott W. Smith, M.D

725 Buckles Ct. N., #210
Gahanna, Ohio 43230 (Phone) 614-245-4263 (fax) 614-245-4269

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: __/__/____

Previous Name: _____ Social Security #: XXX-XX-_____

I request and authorize Stephen P. Smith, Jr., M.D or Scott W. Smith, MD to release healthcare information of the patient named above to:
(Name and address)

_____

_____

This request and authorization applies to:

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

[List here]

○ All healthcare information ○ Other

[List here] _____

[Additional information] _____

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 HEALTHCARE RECORDs, and **if applicable**, any 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 UNDERSTAND THAT THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

_____ ____/____/_____

Signed Date