REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(IS ANYONE OTHER THAN YOU AUTHORIZED TO REQUEST YOUR HEALTH INFORMATION-SUCH AS A FRIEND OR FAMILY MEMBER)

Patient's Name: _____ Date of Birth: _____

Previous name (if applicable): _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relation: _____ Phone number: _____

This request and authorization applies to (check one please):

- Healthcare information relating to the following treatment or condition including 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 venereuem, HIV (Human Immunodeficiency Virus), AIDS, and gonorrhea.

*** Please circle one:**

YES NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person 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 drugs, alcohol, or mental health treatment to the person listed above.

Patient Signature: _____ Date: _____