

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize

\_\_\_\_\_  
Name of physician or hospital

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

to release all healthcare information of the patient named above to:

**Deborah Beutler, M.D.**  
**675 S. Arroyo Parkway**  
**Suite 110**  
**Pasadena, CA 91105**  
**626-243-5211**  
**fax: 626-498-2327**

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.

**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 gonorrhoea.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.**