Pineapple Health

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Authorization To Release Healthcare Information

First Name: | Last Name:

Date Of Birth: | Social Security Number:

Previous First Name: | Previous Last Name:

I Authorize Pineapple Health To:

☐ Obtain My Records From: ☐ Release My Records To :

Facility Name:

Doctor Name:

Address:

City: State: Zip:

Phone: Fax:

This Request And Authorization Applies To:

☐ All Healthcare Information

☐ All Healthcare Information Relating To The Following Date Of Service(s):

Definition : Sexually Transmitted Disease (STD) As Defined By Law, RCW 70.24 Et Seq., Includes Herpes Simplex, Human Papillomavirus (HPV), Condyloma/Genital Warts, Chlamydia, Gonorrhea, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereum, Human Immunodeficiency Virus (HIV) And Accquired Immunodeficiency Syndrome (AIDS).

☐ 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) above will be notified that I must give specific written permission before the 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/Legal Representative: **Date:**

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED