Authorization to Release Healthcare Information to Dr. Grover

Patient's Name: _____ Date of Birth: _____

Patient's Phone: _____

I request and authorize (doctor's name) _____

Doctor's Address: _____
Doctor's City: _____ State: _____ Zip Code: _____
Doctor's Phone: _____ Fax: _____

to release healthcare information of the patient named above to:

Fred Grover Jr. M.D
3400 E. Bayaud Ave. Suite 444
Denver, CO 80209

Fax Preferred: 303-974-5945

The reason for this request is due to: □ PCP Change

□ Other, consultation etc_____

This request and authorization applies to:
□ Healthcare information relating to the following treatment, condition, or dates:
_____
□ All Healthcare information
□ Other: _____
_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., including herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No □ N/A I authorize the release of my STD results, HIV 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 □ N/A I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____

Patient or legally authorized
Individual's signature: _____ Date signed: _____

Thank you.
Please call if any difficulties sending records. 303-355-2385