Authorization to Release Healthcare Information <u>from</u> Dr. Grover to another provider or hospital.

Patient's Name: _____ Date of Birth: _____

Patient's Phone: _____ Social Security #: _____

I request and authorize **Dr. Fred Grover Jr. M.D. to release my records to:**

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

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

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: _____

Release of records if large, may incur a fee of 30 dollars to patient. Please allow 2 wks for delivery. Thank you.

Mail this release to our office at
Fred Grover Jr. M.D.
3400 E Bayaud Ave, Suite 444
Denver, Co. 80209
or
Fax to: 303-974-5945