Paulette Kimball-Wren, MD
Scott R. Cushman, MD
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Worcester Pediatrics, P.C.
123 Summer St #690 North, Worcester, MA 01608
Phone: 508-363-9530 Fax: 833-428-4030

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

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

Name: WORCESTER PEDIATRICS, P.C.

Address: 123 SUMMER ST #690 NORTH

City: WORCESTER State: MA Zip Code: 01608

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., 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 (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ 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.

Signature: _____ Date Signed: _____

Relationship to patient: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.