Pratt Community
HEALTH CLINIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

- ○ Healthcare information relating to the following treatment, condition, or dates:

  _____

- ○ All healthcare information.
- ○ I authorize the release of sexually transmitted disease results, HIV/AIDS testing, whether negative or positive, to Pratt Community Health Clinic.
- ○ I authorize the release of any records regarding drug, alcohol, or mental health treatment to Pratt Community Health Clinic.
- ○ Other: _____

Patient Signature: _____ Date: _____