Dr. Edwin Aguilar

6830 Hospital Drive, Suite 100 & 206
Rosedale, MD 21237
Phone: 410-238-5390
Fax: 410-238-5396

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ Date of Birth: _____

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

Dr. Edwin Aguilar
6830 Hospital Drive, Suite 206
Rosedale, MD 21237
Fax: 410-238-5396

This request and authorization applies to:

Immunization Record _____ Most Recent Physical _____

Laboratory Results _____ Entire Record _____

Healthcare Information relating to the following treatment, condition, or dates; _____

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes 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.

Parent Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.