AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
Freedom Primary Care, LLC

Patient Name:	
Previous Name:	
Date of Birth:	
SSN:	

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

Yvonne Joy, APRN — 1224 Mill Street, Bldg B
Freedom Primary Care — East Berlin, CT 06023
Phone: 860-245-1791

<u>This request and authorization applies to:</u>

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

_____ All healthcare information

_____ Other:

Definition: Sexually Transmitted Disease (STD) as defined by state law, CGS § 19a-2a and § 19a-215, includes herpes, herpes simplex, human papillomavirus, genital wart, condyloma, Chlamydia, Gonorrhea, non-specific urethritis, syphilis, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome).

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.

Patient Signature: ____________________________________Date Signed: __________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.