

TERESA A. MARLINO MD, LLC
255 West Lancaster Ave.
MOB II, Suite 222
Paoli, PA 19301
Ph: 610-647-5111 Fax: 610-647-5113

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Soc. Sec. #: _____

I request and authorize _____

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

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

All health information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes. herpes simplex, human papilloma virus, genital wart, condyloma, chlamydia, syphilis, VDRL, chancroid, lymphogranuloma venereum, 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.

Patient Signature: _____

Date Signed: _____