Mario A. Zapata, M.D.
2424 W. Indian Trail
Suite A
Aurora, IL 60506
Phone: 630-882-0264
Fax: 630-405-6271

MEDICAL RECORDS/HEALTH INFORMATION RELEASE AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

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

_____

_____

_____

This request and authorization applies to:

☐ COMPLETE MEDICAL RECORDS; or

☐ OTHER Healthcare Information relating to the following treatment, conditions, or dates:

_____

☐ YES
☐ NO

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the physician listed above. I understand that the physician listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES I authorize the release of any records regarding drug, alcohol, or
☐ NO mental health treatment to the physician listed above**.**

I understand that I have a right to refuse to sign this Authorization, and to inspect and copy the health information to be released. If I do not sign this authorization, the facility named above will not release my health information based on this Authorization, or if this authorization is granted to obtain insurance coverage, which is covered under other law.

Definition: Sexually Transmitted Disease, 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 venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature:

Date Signed:
