Kirchner
WOMEN'S CLINIC

Dr. Alyson Kirchner, MD, OB/GYN
1339 E. Court St. Ste 210. Seguin, Texas 78155
Phone: 830-379-1500 Fax: 830-379-1290

AUTHORIZATION TO RELEASE HEALTHCARE INFORMTION

Patient's Name: _____ Date of Birth:_____

Previous Name: _____ Social Security #:_____

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

Name: **Kirchner Women's Clinic, PLLC**

Address: **1339 E. Court St., Ste. 210**

City: **Seguin** State: **Texas** Zip: **78155**

This request and authorization applies to:

☐ All healthcare information

☐ 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, 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.

Patient Signature: _____ Date Signed: _____