YOUNIS CARDIOLOGY ASSOCIATES

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date Of Birth: _____

Social Security #: _____

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

Name:

Antoine G. Younis, M.D.
George A. Younis, M.D.

This request and authorization applies to:

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

_____

_____

☐ All healthcare information: _____

☐ Other: _____

Note: This authorization is made at the request of the individual for the purpose of continuity of care.

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, DVRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and ganorrhea

☐ Yes ☐ No

I authorize the release of STD results, HIV and AIDS testing, weather 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 results to anyone.

☐ Yes ☐ No

I understand the release of any records regarding alcohol, or mental health treatment to the person (s) listed above.

Patient's Signature: _____ Date Signed: _____