

CANCER & BLOOD  
SPECIALTY CLINIC

1760 Termino Ave #101  
Long Beach, CA 90804  
562-735-0602

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to

release healthcare information of the patient named above to:

Name: Cancer and Blood Specialty Clinic

Address: 1760 Termino Avenue, Suite 101

City: Long Beach State: CA Zip Code: 90804

This request and authorization applies to:

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

All healthcare information

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 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 my labs results to the voicemail listed above.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that I may refuse to sign this authorization or revoke this authorization at any time by giving written notice to Cancer and Blood Specialty Clinic. This release otherwise is valid for one year from the date I sign it. I understand that my revocation or refusal to sign this authorization form will not affect my ability to obtain health care services or payment or my eligibility for benefits. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand as a patient I have the right to access my records during business hours. Copies of the records may be obtained with reasonable notice and payment of printing cost. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effects as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Record Release Date: \_\_\_\_\_ Staff Name: \_\_\_\_\_