RECORDS RELEASE

To: _____

_____

_____

I hereby authorize the above named health care provider to release the specified information below to:

Cartersville Family Medicine
Benny R. Smith, M.D., Michael Shibley, PA-C
17 Collins Drive
Cartersville, Ga. 30120
Phone: 770-386-9390 Fax: 770-386-0212

Patient: _____

Address _____

_____

Date of Birth _____

This request and authorization applies to:

___ Healthcare information relating to all treatment, condition, or dates _____

___ All healthcare information

Definition: Sexually transmitted disease as define by law, RCW 70.24 et seq, includes herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non specific urethritis, syphilis,VDRL, chancroid, lymphogranuloma veneruem, HIV, AIDS, 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 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.

Signed _____ Date _____