Syracuse Plastic Surgery Skin and Wellness

3107 East Genesee Street, Syracuse, NY 13224

315-299-5313 Fax 315-299-5661

Authorization to Release Healthcare Information

Patient's Name _____ Patient's DOB _____

Former Name _____ SSN _____

I request and authorize _____to release Healthcare information of the patient named above to:

Syracuse Plastic Surgery

Dr. Dean DeRoberts and Dr. Enrique Armenta

3107 East Genesee Street, Syracuse, NY 13224

Fax: 315-299-5661

This request and authorization applies to:

O Healthcare information relating to the following treatment, condition, or dates _____

O All Healthcare information

O Other (please specify) _____

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.

O Yes O 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 tests results to anyone.

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

Patient or Parent/Legal Guardian Signature _____ Date _____

NOTE: If the patient is a minor, a parent or legal guardian must complete below:

Parent/Legal Guardian Name _____ DOB _____

Relationship to patient _____

This Authorization Expires Ninety Days After It Is Signed