SPIRIT
Primary Care

7001 ST. ANDREWS RD. SUITE B9
COLUMBIA, SC 29212
OFFICE: 803-877-4748
FAX: 803-626-0904

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

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

Lauren Svensen Daniels, APRN, FNP-C
7001 St Andrews Rd Suite B9
Columbia, SC 29212

Phone: 803 877 4748 Fax: 803 626 0904

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:_____