Lynde Knowles-Jonas, MD
1236 Huffman Mill Road; Suite 2600
Burlington, NC 27215

Phone: (336) 538-2014
Fax: (336) 538-2015
Email: info@gracewomensclinic.com
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RELEASE OF MEDICAL INFORMATION

(Complete this form to request information from a previous healthcare provider.)

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Doctor: ____

Facility: ______________________ Department: ______________________

Phone: ______________________ Fax: ______________________

Address:

To release healthcare information of the patient named above to:

Grace Women's Clinic, PA
1236 Huffman Mill Rd., Suite 2600
Burlington, NC 27215

Phone: (336) 538-2014
Fax: (336) 538-2015
Email: info@gracewomensclinic.com

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 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: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.