

**Foothills Family Medicine**  
4530 E. Ray Rd., Ste. 172  
Phoenix, AZ 85044  
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**Dr. Kevin Chan, D.O., M.S.**  
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Authorization to Release Healthcare Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Previous First Name: \_\_\_\_\_ Previous Last Name: \_\_\_\_\_

I authorize Foothills Family Medicine to:

\_\_\_\_\_ Obtain My Records From: \_\_\_\_\_ Release My Records to:

Facility Name: \_\_\_\_\_  
Doctor Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ All Healthcare Information. \_\_\_\_\_ All Healthcare Information relating to  
the following date of service(s):  
\_\_\_\_\_

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papillomavirus (HPV), condyloma/genital warts, chlamydia, gonorrhea, syphilis, VDRL, chancroid, lymphogranuloma venereum, Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS).

\_\_\_\_\_ 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) 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 if any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_