

# ***NORTH AUSTIN SPORTS MEDICINE***

12176 N. Mopac, Ste D Austin, Texas 78758 (512) 977-0000 fax (512) 977-0020

S. BRENT BROTZMAN, M.D.

ROBERT D. GRAHAM, II, M.D.  Please check which doctor ☺

CAMILLE M. BARTON, PA-C

STEPHEN GRIFFIN, PA-C

## **AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release health care information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

office # \_\_\_\_\_ fax # \_\_\_\_\_

**This request and authorization applies to:**

- Health care information relating to the following treatment, condition or dates:

\_\_\_\_\_

- All health care information.

- Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, condyloma, cyamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea. Pregnancy Test Results, drug/alcohol, mental health information may also be included.

**By signing below I am authorizing all my medical records, as disclosed and described above to be release.**

Signature : \_\_\_\_\_ Date \_\_\_\_\_

Office use:  
Mailed/Picked Up \_\_\_\_\_ Initials \_\_\_\_\_