Lehmann Chiropractic & Sports Injury Center

PHONE (419) 435-2900, FAX (419) 435-2901

AUTHORIZATION TO RELEASE HEATHCARE INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME: _____ SS NUMBER: _____

I REQUEST AND AUTHORIZE: _____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

DR STEVEN D. LEHMANN DC
231 W. TIFFIN STREET
FOSTORIA, OHIO 44830

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- HEALTHCARE INFORMATION RELATING TO THE FOLLOWIN TREATMENT, CONDITION, OR DATES: _____
- ALL HEALTHCARE INFORMATION
- OTHER: _____

DEFINITION: SEXUALLY TRANSMITTED DISEASE AS DEFINED BY LAW, RCW 70.24 ET SEQ., INCLUDES HERPES, HERPES SIMPLEX, HUMAN PAPILLOMA VIRUS, GENITAL WART, CONDYLOMA, CHLAMYDIA, NON-SPECIFIC URETHIRITIS, SYPHILIS, VDRL, CHANCROID, LYMPHOGRANULOMA VENEREUEM, HIV, AIDS, AND GONORRHEA.

I AUTHORIZE THE RELEASE OF MY STD RESULTS HIV/AIDS TESING WETHER NEGATIVE ORPOSITIVE TO THE PERSON(S) LISTED ABOVE. I UNDERSTAND THAT THE PERSON(S) ABOVE WILL NOT RELEASE THIS INFORMATION WITHOUT MY PERMISSION.

☐ YES
☐ NO

I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO THE PERSON(S) LISTED ABOVE.

☐ YES
☐ NO

PATIENT SIGNATURE: _____ DATE: _____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED.