395 W. Central Avenue, Brea, CA 92821
www.BreaUrgentCare.com

HOURS:
Mon - Fri: 8am - 8pm
Sat & Sun: 8am - 6pm

714.494.2828
714.482.2871 Fax

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________ Date of Birth: _________/__________/_________

Previous Name: ______________________________ Social Security #: [| | | | | | | |]

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

Name: Brea Urgent Care

Address: 395 W. Central Avenue

City: Brea State: CA Zip Code: 92821

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 Disease (STD) as defined by law, RCW70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results and/or 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