***Sérénité Medical & Spa***

*Dr. Francess Bataille PCP*

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3771 Fettler Park Drive

Dumfries, VA 22026

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | | |
| Previous Name: | | | | | | |  | | | | Social Security #: | | | |  | | | | | |
| I request and authorize | | | | | | | | | | Francesse Bataille, MD | | | | | | | | | | to |
| release healthcare information of the patient named above to: | | | | | | | | | | | | | | | | | | | | |
|  | | Provider/Clinic: | | | |  | | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | | Zip Code: | | |  | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This request and authorization applies to: | | | | | | | | | | | | | | | | | | | | |
| 🞎Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 🞎All healthcare information | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎Billing/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 12 MONTHS AFTER IT IS SIGNED.