

# Nature Coast Women's Care

Chukwuma M. Okoroji, M.D., FACOG

2473 Care Drive, Suite 102, Tallahassee, FL 32308

Phone: (850) 320-6054 Fax: (850) 320-6961

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_

**(Address/Phone/Fax)** \_\_\_\_\_

to release healthcare information of the patient named above to:

Name: NATURE COAST WOMEN'S CARE

Address: 2473 CARE DRIVE , SUITE 102

City: TALLAHASSEE State: FL Zip Code: 32308

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

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

**Definition:** A sexually transmissible disease is defined to mean a bacterial, viral, fungal, or parasitic disease, determined by the Department of Health to be sexually transmissible, to be a threat to public health and welfare. Section 384.23(3), Florida Statutes. The Department of Health has designated the following diseases as sexually transmissible diseases: Acquired Immunodeficiency Syndrome; Chancroid; Chlamydia trachomatis; Gonorrhea; Granuloma Inguinale; Human Immunodeficiency Virus Infection; Lymphogranuloma Venereum; Syphilis; Herpes; Herpes Simplex; Hepatitis B and Hepatitis C ;. Rule 64D-3.015, Florida Administrative Code.

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 NINETY DAYS AFTER IT IS SIGNED.

