Valora Medical Group

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO VALORA

Fill out this form if you want your records from your previous doctor be sent to our office.

Patient's Name: _____ DOB: _____

Previous Name: _____ SSN: _____

Address: _____ City: _____

State: _____ Zipcode: _____ Phone: _____

I request and authorize release healthcare information of the patient named above from:

Physician Name: _____

Address: _____

Phone: _____ Fax#: _____

Records as listed below should be mailed or faxed to **VALORA Medical Center** to the address or fax listed at the bottom. This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ 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: _____

Witness: _____ Date Signed: _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS AUTHORIZATION IS VALID FOR UNTIL REVOKED IN WRITING BY ME.

VALORA MEDICAL GROUP
5601 Executive Drive, Suite 200
Irving, TX 75038
Office: (469) 833-2731 • Fax: (817) 697-4179