Nonnie Estella, MD
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North Chelmsford, MA 01863
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____Social Security#: _____

I request and authorize ***Nonnie Estella, MD***
to release Healthcare information of the patient named above:

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 70.24et seq., includes herpes, herpes simples, human papilloma virus, warts, 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 a specific written permission before disclosure of these test results to anyone.

Yes◯ No◯ I authorize the release of any records regarding drugs, alcohol, or mental health treatment to person(s) listed above.

A Fee of $25.00 for copy of medical records

Patient Signature: _____ Date Sign: _____