



Daniel Curtin, MD

2870 State Route 21, Wayland, NY 14572

Phone: 585-728-2070

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security No: _____

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

Name: Dr. Daniel Curtin c/o Wayland Family & Sports Medicine, P.C.

Address: 2870 State Route 21

Town: Wayland State: NY Postcode: 14572

This request and authorization applies to:

- All Healthcare Information
- Healthcare information relating to the following treatment, condition or dates: _____

Other: _____

- 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.
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 venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

- 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.