



Regina M. Burton, M.D.,PC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ To
Release all healthcare information of the patient named above to:

Name: Regina M. Burton, M.D.

Address: 10721 Main Street Suite 2100

City: Fairfax State: VA Zip Code: 22030

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates: _____

All health care information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW70.24 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, wheter 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