Dr. Amanda Pennington

1721 Ebenezer Rd Suite 205 Rock Hill SC 29732

Phone: 803-328-6733 Fax:717-674-4186

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

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

Amanda Pennington, M.D.

1721 Ebenezer Rd Suite 205 Rock Hill SC 29732

Phone: 803-328-6733 Fax: 717-674-4186

This request and authorization apply 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 warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

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 that release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

- ❑ Yes
- ❑ No

Patient Signature: _____ Date Signed: _____