George Nassif, M.D

42621 Garfield Rd., Suite 108
Clinton Township, MI 48038
Phone: 586-263-3312 Fax: 586-263-5311

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (print):_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

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

FROM:

Physician/Hospital: _____

Telephone#:_____ Fax#:_____

TO: **Dr. George Nassif, MD**
42621 Garfield Rd., Suite 108
Clinton TWP, MI 48038
Telephone: 586-263-3312 Fax: 586-263-5311

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:_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.