RELEASE OF HEALTH CARE INFORMATION TO SIA-LLC

Patient Name: _____ Previous Name: _____

I request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____)_____ FAX: _(____)_____

To release health care information of the patient named above to:

Southern Illinois Associates, LLC

16 Junction Drive West, Ste 2

Glen Carbon, IL 62034

Phone: 618-288-5019

Fax: 618-288-5059

This request and authorization applies to:

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

_____

_____All health care information

_____Other: _____

The Purpose of the disclosure:

_____Coordination of Care

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's name

Patient’s or Representative's Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 days (OR days) AFTER IT IS SIGNED.