



JAMES J. LONGOBARDI, DPM
450 FOURTH AVE, STE.401
CHULA VISTA, CA 91910
TEL: (619) 425 - 8800

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____ last 4 numbers only

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

Name: JAMES J. LONGOBARDI, DPM
Address: 450 FOURTH AVENUE, SUITE 401
City: CHULA VISTA State: CA Zip: 91910

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 90 DAYS AFTER IT IS SIGNED *****