ABSOLUTE FOOT CARE
a gentle approach to foot care

JAMES J. LONGOBARDI, DPM
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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 * * **