Woodbridge
Internal Medical Associates, P.A.

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Gastroenterology
Seth M. Webber, M.D.
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

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

Name: *Woodbridge Internal Medical Associates, P.A.*

Address: *1000 Route 9 North, Suite 302*

City: *Woodbridge* State: *N.J.* Zip Code: *07095*

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

☐ Immunization Records ☐ Most recent progress notes ☐ Labs ☐ Imaging Studies

☐ Cardiology Testing (i.e. stress test, echo) ☐ GI procedures

☐ Other: ____

☐ All healthcare information

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 NINETY DAYS AFTER IT IS SIGNED.