

# Mitchell Family Medicine

2931 Long Prairie Road Suite 100, Flower Mound, TX 75022  
Phone: 972-355-3771 Fax: 972-539-5870

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I request and authorize:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

to release healthcare information of the patient named above to:

**Mitchell Family Medicine  
Ronnie Mitchell, D.O., P.A.  
2931 Long Prairie Road Suite 100  
Flower Mound, TX 75022**

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.

I may revoke this authorization at any time, but not retroactively.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_