Gender And Sex Therapy Clinic, LLC

1525 NE Weidler, Suite 101 Portland, OR 97232

Phone: 360.909.2489 - Fax: 530.296.5758

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:**_____

Previous Name: _____

I hereby authorize the following entity to release information to the office listed in the heading above:

Name of Provider: _____

Address : _____

City : _____ **State:** _____ **Zip Code:** _____

Fax: _____ **Phone:** _____

This request and authorization applies to:

1# □ I authorize Sue Ujvary to discuss my mental health situation on the phone or video call with this provider.

2# □ Healthcare information relating to the following treatment condition or dates:_____

_____

3# □ Other:

□ 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 my prescription medication history, including any and all pharmaceuticals, alternative medicine and natropathic remedies to the person listed above.

□Yes □No I authorize the release of any records drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date:** _____