Dr. Kelly Ennix King
505 S. Eichenfeld Suite 107
Brandon, Florida 33511
Phone: (813) 651-3492 Fax: (813) 651-3493

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____(Primary Doctor) _____(Phone/Fax)

to release healthcare information of the patient named above to:

Dr. Kelly Ennix King

505 S. Eichenfeld Suite 107

Brandon, Florida 33511

Phone: (813) 651-3492 Fax: (813) 651-3493

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

List Here_____

○ All healthcare information ○ Other

List Here_____

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.