3560 Meridian Street Ste. 101, Bellingham WA 98225
I Phone: (360) 734-2800 I Fax: (360) 734-3818 I www.averodx.com I

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

A. Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Telephone #: _____ Email Address: _____

Previous Name: _____ Social Security #: _____

B. Authorized Representative:

Name of Representative: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Telephone #: _____ Relationship: _____

I hereby request and authorize Avero Diagnostics to release healthcareinformation of the patient named above to:

☐ Self (I am the Patient or Authorized Representative listed above)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

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.

Please note: *A minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted disease (if age 14 or older), HIV (AIDS virus) (if age 14 or older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).*

☐ 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.

My Rights:

1) I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
    - To receive research-related treatment in connection with research studies OR
    - To receive health care when the purpose is to create health care information for a third party.
2) I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Avero Diagnostics in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
    - Fill out a revocation form – a form is available from Avero Diagnostics or
    - Write a letter to Avero Diagnostics.

Protection after Disclosure: I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it. This authorization is subject to my revocation at any time, except to the extent action has been taken in reliance thereon; and unless earlier revoked, shall expire one year after the date of signature.

Patient Signature	Date Signed
Signature/Legal Representative	Date Signed
Relationship/Representative	Witnessed by
Proof of Identity	Proof of Legal Representative is attached

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

** ~~**A copy of patient's drive license/valid photo ID MUST be attached**~~ **