



## AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize QueerDoc PLLC and its authorized providers to release information to:

Organization/Recipient: \_\_\_\_\_

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

Phone #: \_\_\_\_\_

Information to be released:

\_\_\_\_\_ Clinic notes \_\_\_\_\_ Other:

Purpose of release:

\_\_\_ Continuing Care \_\_\_ Legal \_\_\_ Copies for own use \_\_\_ Transfer to another provider  
\_\_\_ Coordination with work or school \_\_\_ Other (please specify) \_\_\_\_\_

Release requiring specific consent

MINORS: A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older) and 2) mental health conditions (age 13 and older) and 3) Drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2).

I specifically authorize QueerDoc PLLC to release information checked below:

\_\_\_ Reproductive care \_\_\_ Sexually Transmitted Diseases (including HIV/AIDS)  
\_\_\_ Mental Health \_\_\_ Drug/Alcohol Abuse  
\_\_\_ Gender Health

Complete this section if you are under the age of 18:

Signature of Minor Patient \_\_\_\_\_

Printed Name \_\_\_\_\_

Print legal/health insurance name: \_\_\_\_\_

Date and time \_\_\_\_\_



Signature Required for Release of Information

I understand that:

Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I can cancel this authorization at any time with a written request to QueerDoc PLLC/Crystal Beal, MD. This authorization will expire one year from the date signed below unless another date or event is entered here: \_\_\_\_\_.

Signature of Patient or Legal Representative

\_\_\_\_\_

Printed name \_\_\_\_\_

Printed legal/health insurance name: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Phone number

\_\_\_\_\_

Date and Time Signed

\_\_\_\_\_