AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # (last 4 digits): _____

I request and authorize (from) _____ to

release healthcare information of the patient named above to:

Name: Linda A Kiley, MD and Ultra Health & Wellness LLC

Address: 4270 Design Center Dr #100A

City: Palm Beach Gardens State: FL Zip Code: 33410

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Fax to patient ☐ Fax to Provider at 855-844-8455 ☐ Mail to patient ☐ Patient pick up

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: _____

If not signed by the patient, then indicate relationship: _____

Linda Kiley, MD
Ultra Health & Wellness, LLC
4270 Design Center Drive #100A
Palm Beach Gardens, FL 33410
561-701-2841