CIAMPI
FAMILY PRACTICE
380 Lincoln Street South Portland, Maine 04106

Authorization To Release Medical Records

Patient Name: _____ Date of Birth:_____

Previous Name(s): _____

I request and authorize Michael A. Ciampi, M.D. to release healthcare information of the patient named above to:

Name: _____

Address: _____

Tel. #_____ Fax# _____

This request applies to:

☐ All healthcare information

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

☐ Other: _____

Reason for this request: _____

☐ Yes ☐ No I authorize release of my STD results, HIV/AIDS testing, whether positive or negative, to the person listed above. I understand that the person 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, and mental health treatment to the person listed above.

Definition: Sexually Transmitted Diseases (STDs) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient/Guardian Signature: _____ Date:_____

THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE IT IS SIGNED.