a.l.p.h.a.
EDUCATE | TEST • SUPPORT

537 W Bannock St Ste 100 | Boise, ID 83702
Phone: 208-424-7799 | Fax: 855-239-2005| Chris.Bidiman@alphaidaho.org | alphaidaho.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Allies Linked for the Prevention of HIV & AIDS
537 W Bannock St Ste 100
Boise, ID 83702
Phone: 208-424-7799
Fax: 855-239-2005

Doctor/Organization:_____

Address:_____

Phone:_____

Fax:_____

I authorize a.l.p.h.a. to: ☐ Release information to the above organization.

I authorize the above organization to: ☐ Release information to Allies Linked for the Prevention of HIV & AIDS

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) 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 ONE YEAR AFTER IT IS SIGNED.