**IDAOC** Infectious Disease Associates of Orange County

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Tuan Ta, M.D.

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ________________________ Date of Birth: ______________ Social Security #: _________________

I hereby request and authorize ___________________________________________________________ to release my healthcare information to the doctors and office staff of Infectious Disease Associates of Orange County.

***Records to be SENT TO:***
Infectious Disease Associates of Orange County (IDAOC)
Attention: Medical Records
999 N Tustin Ave, Suite #109
Santa Ana, CA 92705
Fax: 714-664-0049

This request and authorization applies to:

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

_________________________________________________________________________________

_________________________________________________________________________________

**Definition:** Sexually Transmitted Disease (STD) as defined by law RCW 70.24 et seq., is a sexually transmitted bacterial, viral, fungal, or parasitic disease that is a threat to the public health and welfare, and is a disease for which a legitimate public interest will be served by providing for regulation and treatment. It is designated that STD includes herpes simplex virus, human papilloma virus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, chancroid, lymphogranuloma venereum, 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.

Signature: ______________________________________ Date Signed: _________________________

**THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER DATE SIGNED**