JSR HEALTH PLLC

Dr. Jaya Sonkar, MD, MPH
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ DOB_____

Previous Name _____ SSN#_____

I request and authorize my **Primary Care Physician** and **Specialists Offices** to release my healthcare information to my Rheumatologist: **Dr. Jaya Sonkar (JSR Health PLLC)**
Office Address: 21216 Northwest Freeway, Suite 230, Cypress Texas-77429

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition _____

or dates **From:** _____ **To:** _____

☐ All healthcare information, other.

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, and 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.

Type Full Name: _____

_____ _____

Signature of Patient or Responsible Party Signature Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.