Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Parkway, Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: Akindele Kolade, MD - Cal Psychiatric Services

Address: 3201 S. Maryland Parkway, Suite 318

City: Las Vegas **State:** NV **Zip Code:** 89109

Phone: 702-629-7490 **FAX:** 702-629-7685

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) 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 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.

Date: _____

_____ _____

Signature of Patient Date Signed:

AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.