



**City and County of San Francisco**  
**Department of Public Health**  
**STD Prevention & Control**  


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**City Clinic**

**Consent for Release of Medical Information**

I understand that I am disclosing that I may have received health care service related to the diagnosis or treatment of Sexually Transmitted Diseases (STD).

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(City/State) (Zip Code)

Date of Birth: \_\_\_\_\_ Clinic #: \_\_\_\_\_

I hereby authorize the Department of Public Health, STD Control, to release my medical records to:

\_\_\_\_\_  
(Name, Title, and Address of Person or Organization)  
\_\_\_\_\_

- A. Use: The requester may use this information only for this stated purpose.
- B. Duration: This authorization shall become effective immediately and shall remain in effect until: \_\_\_\_\_
- C. Restrictions: I understand that the requester may not further use or disclose the medical information unless authorization is obtained from me or disclosure is required or permitted by law.
- D. Copy: I have the right to receive a copy of this authorization upon my request:  
 Yes     No     Initials

Please provide the following information related to medical examination:

Report Period, from \_\_\_\_\_ to \_\_\_\_\_

Lab Results for the Condition of: \_\_\_\_\_

Physician's Finding for: \_\_\_\_\_

Other: \_\_\_\_\_

If signed by other than the patient, please indicate relationship:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MAKE DUPLICATE COPIES

Today's Date: _____
Paid:   Cash   Check   Fee Waived
Check #: _____
Date Records were Released: _____
Released by: _____

<b>Copy Photo ID Here</b>
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