Dr. Sue Mitra, MD
397 N. Wickham Road, Suite 101
Melbourne, FL 32935
Phone: (321) 622-6222

MAB
MEDICAL ASSOCIATES OF BREVARD

Authorization to Obtain Healthcare Information

Patient's Name _____

Address _____

Phone _____ DOB ___/___/_____ Social Security # _____-____-_____

I request and authorize (previous physician's name) _____
to release healthcare information of the patient named above to:

Dr. Sudeshna Mitra
397 N. Wickham Rd., Suite 101
Melbourne, FL 32935

This request and authorization applies 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, 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 ___/___/_____

This Authorization Expires Ninety Days After It Is Signed.