DAJA Health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please include a telephone number or fax where you want us to send the request.

Patient's Name: _____ Phone # _____

Previous Name: _____Date of Birth: _____

I request and authorize: _____
(Doctor's Name or Facility Name)

_____
Phone Number or Fax (**Requests with no number will not be faxed**)

release healthcare information of the patient named above to:

Name: DAJA HEALH, LLC

Address: 6305 IVY LANE, SUITE 260

City: GREENBELT State: MD Zipcode 20770

This request and authorization apply to the following:

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

_____All healthcare information

_____Other: _____

__**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.

Patient Signature: _____Date Signed: _____

This information is intended solely for the named recipient(s). Any unauthorized interception of this information breaches federal and state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action concerning the document's contents is strictly prohibited. If you have received this information in error, please notify us to arrange for the return or disposal of the document.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED OR ON THE SPECIFIED DATE.

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www.dajahealth.org