SNOHOMISH COUNTY HEALTH DEPARTMENT

Authorization to Release Protected Health Information

PLEASE PRINT CLEARLY

Reason for Request:

☐ Medical ☐ Personal ☐ Legal ☐ Other: _____

This Request & Authorization Applies To:

☐ Immunization records ☐ Lab reports ☐ Evaluation & treatment of Tuberculosis ☐ Other: _____

Patient/Child (Legal Name): (if requesting records for more than one person, please complete a separate request)

First name:	Middle name:	Last name:	
Date of birth (mm/dd/yyyy):	Previous names (i.e. maiden, nicknames):		Contact phone number:

Parent/Guardian Information: (if patient is less than 18 years old)

First name:	Middle name:	Last name:	
Date of birth (mm/dd/yyyy):	Email:		Contact phone number:
Street address:	City:	State:	Zip:

I request & authorize the *Snohomish County Health Department* to exchange with or release health care information of the person named above to:

Name:	Phone:	Fax:	
Street address:	City:	State:	Zip:

Records requested by fax, mail or pick-up will be available 5-10 business days after receipt of this request. Please check a box and complete the information below:

☐ Fax	☐ Mail			☐ Pick-up
Name:	Name:			Snohomish County Health Department 3020 Rucker Ave., Suite 104 Everett, WA 98201
Fax:	Street address:			
	City:	State:	Zip:	

Sensitive Information: This authorization includes the release of the following sensitive information *unless specifically excluded*. Please CHECK if you DO NOT want this RELEASED.

☐ Mental health/psychiatric disorders ☐ HIV/AIDS ☐ Sexually transmitted diseases ☐ Drug & alcohol treatment ☐ Hepatitis B & C

I understand that once this information is released it has the potential to be re-released and may no longer be protected by state or federal privacy laws.

This authorization expires on (date or event) _____, or 12 months from the date signed if not specified. A copy of this document may be considered the same as the original.

Signature:

Signature of client or client's authorized representative (required):	Date signed (mm/dd/yyyy):
Relationship or status if signed by anyone other than client (parent, legal guardian, client authorized representative, etc.):	
Signature of interpreter:	Date signed (mm/dd/yyyy):

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