

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 *Snohomish Health District*, 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:

<input type="checkbox"/> Fax	<input type="checkbox"/> Mail	<input type="checkbox"/> Pick-up
Name:	Name:	Snohomish Health District 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

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):

HR_Auth_Release_Health_Info_2018_04_v5_LML