Authorization to Disclose Health Information

Last Name:	First:	M.I.:
Other Name(s) Used:		
Date of Birth:	Phone #:	

Address:	City:	State:	Zip:

I request that my protected health information (PHI) be obtained from:

Individual/Agency:			
Phone #:	Fax #:		
Address:	City:	State:	Zip:

I request that my protected health information (PHI) be provided to:

Individual/Agency:			
Phone #:	Fax #:		
Address:	City:	State:	Zip:

I authorize the following PHI to be disclosed:

☐ Immunization record ☐ Treatment Records ☐ Diagnosis Records
☐ Care Plan ☐ Case/Progress Notes ☐ Prescriptions
☐ Tuberculosis Testing/Treatment ☐ Entire Record ☐ STD Records
☐ UA/BA Results ☐ Blood/Lab Results
☐ Other: _____

Disclose PHI for these specific dates: _____ to _____

I understand information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released:

Alcohol/Substance Abuse Records Yes ☐ No ☐ **Dates:** _____

HIV Testing and Results Yes ☐ No ☐ **Dates:** _____

Mental Health Record Yes ☐ No ☐ **Dates:** _____

Psychotherapy Records Yes ☐ No ☐ **Dates:** _____

Reason for disclosure of health information:

☐ At my request ☐ Coordination of Care ☐ Legal ☐ Employment ☐ School

☐ Other: _____

Additional Client Information:

Conditions. We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by state laws (RCW 70.02) and federal laws 42 CFR Part II.

Expiration. This authorization shall expire three hundred sixty-five (365) days from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation. You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Any facsimile copy or photocopy of the authorization shall authorize you to release the records requested herein. By signing below, you acknowledge receipt of a signed copy of this authorization.

Client signature (Parent or Legal representative, if applicable)	Date
Print Name	Relationship/Authority

**Attach legal documentation if you are the legal guardian or have medical power of attorney*

Spokane Regional Health District assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. To file a complaint or to request more information, reasonable accommodations, or language translations, contact 509.324.1501 or visit srhd.org.

Internal Use Only:					
Date received:		Received by:			
Date forwarded:		Request forwarded to:		Division:	
Copies provided by:					
Copies provided on:					
Brief description of records provided:					