



343-NonDOH March 2011

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Public Health is not obligated to honor this request unless all portions are completed.

The undersigned authorizes:

- Tuberculosis Control Program
Public Health Seattle-King County
325 Ninth Avenue, Box 359776
Seattle, WA 98104
206-744-4579
- Outside Agency

To release the records of:

Client Name _____ Client Phone # _____
 Date of Birth _____ Health Record Number _____

Records will be released to:

Person & Institutional Affiliation _____
 Street Address _____ City/Zip _____

This release covers the following date(s): [If no date given: the last two (2) years of data will be released; if a correctional health services request, the last incarceration information will be released]. *If Medic One request, also indicate time and location of encounter with Medic One.*

List requested dates here: _____

For the purpose of: medical legal personal other: _____

Unless revoked or as otherwise provided herein, this authorization expires _____ (insert either applicable date or event). Is the person or organization to which the client's records will be released an employer or financial institution, i.e., bank? Yes No If yes, this authorization will expire 90 days from date signed (or such earlier date as indicated on the authorization).

Records Requested: (Photo identification may be required to verify identity)

- Clinic or Care Coordination Records
- Immunization Records
- Autopsy Records
- Other: _____
- WIC Records
- Medic One (include time & location)
- Billing Records

*** This is a permanent part of the health record ***

Authorization for use and disclosure of protected health information



Client Name:
HR#:
D.O.B.:

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization **excludes** release of the following types of information:

- Drug or alcohol abuse diagnosis or treatment
- Confirmed STD test results and/or treatment
- HIV (AIDS) testing/treatment
- Psychiatric care/mental illness

Client/Guardian Signature

Date

Relationship

Interpreter

Date

Client Rights

Your rights under federal and state law:

You may revoke this authorization at any time. It must be in writing. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable.

Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form.

When Public Health asks you to fill out this authorization, you are entitled to a copy.

When Public Health discloses your health information, your protected health information can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

*** This is a permanent part of the health record ***

Authorization for use and disclosure of protected health information

Public Health
Seattle & King County



Client Name:
HR#:
D.O.B.: