Authorization For Verbal and Written Exchange of Protected Health Information  
Public Health is not obligated to honor this request unless all portions are completed

The undersigned authorizes:  
Public Health Seattle & King County  
401 Fifth Avenue, Suite 1300  
Seattle, WA 98104-1818

To verbally or in writing exchange the protected health information of:

Client Name

Alias (Optional)

Client Phone #

Date of Birth

Information will be exchanged with:

Name of Person & Name of Agency or Clinic

Street Address

City/State/Zip

Phone Number

Fax Number (Optional)

Date(s) of service requested:

Records Requested:

☐ Jail Health Services (If no date given the last incarceration information will be released)

☐ Other Public Health Medical Records, specify Public Health site(s):

When checked, this authorization EXCLUDES release of the following information:

☐ Drug or alcohol abuse diagnosis or treatment

☐ Confirmed STD test results and/or treatment

☐ HIV (AIDS) testing/treatment

☐ Psychiatric

This authorization expires (insert date or event) invalid if left blank

Is the recipient an employer or financial institution? (If yes, this expires 90 days from signature date) ☐ Yes ☐ No

Your rights under federal and state law:

You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending a written revocation. 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. You are entitled to a copy of this form. Information disclosed by Public Health in accordance with this authorization is no longer protected by Public Health.

The information disclosed in accordance with this authorization is from records protected by Federal (42CFR Part2) and state (REW 70.02) confidentiality rules which prohibit any further disclosure of this information unless permitted by the written consent of the person to whom it pertains or as otherwise permitted by the aforementioned Federal and state rules.

Client/Guardian Signature __________________________ Relationship to Patient __________________________ Date ____________

Interpreter __________________________ Date ____________

Authorization for Verbal/Written Exchange of PHI (English)

Compliance Office  
Public Health – Seattle & King County  
401 Fifth Avenue, Suite 1300  
Seattle, WA 98104-1818

Phone: 206-263-9700  
Fax: 206-205-3945

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