AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name____________________ BD__________ SS#__________

Information **released** from: ______________________________
Name of designated Facility or Provider

____
Address

____________________ (___)__________
City, State, zip Phone

Information to be **sent** to: ______________________________
Name of designated Facility or Provider

____
Address

____________________ (___)__________
City, State, Zip Phone

Information to be released: ____All records ____Progress notes only ____Immunizations only

Specifically **Include** Or **Exclude (Circle One):** ______________________________

____

Purpose for which disclosure is being made: ______Doctor ______Insurance ______ Attorney ______Personal

I understand that my express consent is required for you to release information relating to sexually transmitted disease, mental illness, and/or drug/alcohol abuse, pursuant to Washington Law RCW 70.24 ET. SEQ.

- If I have been tested, treated, or diagnosed in connection with any sexually transmitted disease, or drug/alcohol abuse, and/or mental illness, you are ***specifically authorized to release*** to the person or entity named above all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded above.

MY RIGHTS: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

CONSENT OF MINOR

Where a minor has the right to consent to medical treatment, he or she also has the right to control information related to that treatment. A competent minor patient's signature is required to release information related to care of: 1) birth control for minors deemed mature [WA case law]; 2) treatment for HIV/AIDS sexually transmitted diseases for patients age 14 and above; [RCW 70.05.070, RCW 70.24.110]; 3) to receive HIV/AIDS or STD test results for patients age 15 and above [RCW 70.24.105]; 4) outpatient treatment for alcoholism and drug abuse for patients age 13 and above; [RCW 70.96A.095]; and 5) mental health conditions for patients age 13 and above [RCW 71.34.030(1)]

Signature of minor:______________________________ Date:__________

____________________	____________	____________	____________
Parent or Legal Guardian Signature	Relationship	Phone	Date

This authorization expires 90 days after the date signed.

Revised 5/2014