

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize/request this patient's records be released:

Patient Name: _____ Patient DOB: _____

Also known as (optional): _____

Release records from:

Jail Health Services (JHS) KC Medic One Public Health Clinic (write in clinic): _____

Other: _____

Release records to:

Name Company (if applicable)

Phone Number Email

Fax Number Street Address City/State/Zip

Record Dates: _____

If no date given (non-KC Medic One requests): last 2 years or most recent jail stay will be released.

Record Types:

All Medical Records (visit notes, medications, labs, diagnoses, test results) Verbally Release Information

Vaccination Records Dental Records X-ray Images Billing Records Other: _____

KC Medic One Records:

Address or cross street of KC Medic One care: _____

Time and date of KC Medic One care: _____

Purpose of Request: Legal Payment Health Care Other: _____

I understand that these records may contain information regarding Sexually Transmitted Disease (STD) and HIV/AIDS testing, diagnosis, and/or treatment, Substance Use Disorder (SUD), i.e. drug and/or alcohol abuse evaluation, diagnosis and/or treatment, and Mental Health information unless I check a box or boxes below.

Do NOT include the following information:

STD/HIV/AIDS Testing/Diagnosis/Treatment SUD Evaluation/Diagnosis/Treatment Mental Health Information

This authorization/request is valid until this date or event: _____

If no date/event given, or records are for patient's employer or financial institution for non-payment purposes: authorization expires in 1 year.

Patient or Authorized Adult Signature

Authorized Adult Relationship to Patient

Date

Interpreter

Date

Notice:

You may revoke (take back) this authorization at any time by telling Public Health in writing you are revoking the authorization. The revocation will not apply to any records already released. Public Health may not refuse treatment, payment, enrollment, or eligibility for benefits just because this form isn't signed. The person or organization receiving the requested records may release them to others depending on applicable laws. You may have a copy of this form.



Health Information Management

Public Health – Seattle & King County
401 5th Ave, Suite 1220
Seattle, WA 98104-1818

Phone: 206-263-9700

Fax#: 206-788-8433

DPHROIHotline@KingCounty.gov

PATIENT NAME:

DOB:

MRN: