IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

, Plaintiff, v. , Defendants.	NO. STIPULATION AND AUTHORIZATION RE HEALTH CARE RECORDS OF DOB: SSN: [redacted]-____

TO: **HEALTH CARE PROVIDERS AND FACILITIES:**

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

RE YOUR PATIENT: _____

, authorizes you to disclose all health care information as provided in this stipulation.

A. Purpose of Stipulation: The plaintiff is stipulating to the release of all health information to facilitate procurement of medical records for litigation purposes.

It is plaintiff's position that this Stipulation does not affect, in any way, the plaintiff's fundamental right to privacy or his fiduciary relationship with his health care providers.

B. Nature of Information to be Disclosed: All health care information whether oral or recorded in any form or medium, that directly relates to the patient's health care including any record of disclosures of health care information, also.

C. The attached declaration and authorization expresses the plaintiff's position as to his right or privacy vis-a-vis health care providers.

D. Specific Release: I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. If Ambrose Anderson has been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

E. Manner of Disclosure: Copies of medical records shall be obtained and distributed as follows:

1. Defendant shall direct this Stipulation to the appropriate records custodian;

2. The records custodian shall provide one copy of the records, and identify x-rays, pathology slides and other physical documentation, together with a form signed by the custodian stating the following:

a. The name and address of the custodian;

b. That as of the date signed, the records are the complete and accurate records of the patient.

3. The copies of the medical records shall be mailed or provided to a professional copying service, who shall number each page consecutively in the lower right-hand corner of each page, commencing with page 1, and serially thereafter.

4. Unless a party to the stipulation has stated in writing that s/he does not want a copy of the records, the professional copying service shall make one additional copy of the records and distribute the documents as follows:

a. The documents received from the health care facility shall be delivered to defense counsel, who shall pay one-half (1/2) of the costs incurred.

b. The newly made copies shall be delivered to plaintiff's counsel, who shall pay one-half of the costs incurred.

c. If plaintiff's counsel does not desire a copy of the records, as indicated below, then defendant shall pay the entire cost of obtaining the documents.

5. X-rays, pathology slides and other physical documentation shall be identified only, but should be retained by the health care facility or provider.

F. The parties stipulate that the records produced in accordance with this stipulation are authentic medical records regarding _____. I have agreed to the provision because I have been required by court order. No other objections are waived.

G. A photocopy of the executed original of this stipulation shall be valid as the original.

H. Counsel for the parties to this stipulation shall promptly pay the costs incurred.

I. This authorization form is effective on the date signed below and is valid for ninety (90) days from this date.

DATED this _____ day of _____, 2011.

SCHROETER, GOLDMARK & BENDER

SCHROETER, GOLDMARK & BENDER

Do you want a copy?

Yes_____No_____

By _____
JANET L. RICE, WSBA #9386
KRISTIN HOUSER, WSBA #7286
Counsel for Plaintiffs
500 Central Building
810 Third Avenue
Seattle, WA 98104
(206) 622-8000

DATED this _____ day of _____, 2011.

(FIRM NAME)

Do you want a copy?

Yes_____No_____

By _____

Counsel for Defendant _____

DECLARATION AND AUTHORIZATION

1. I have read the stipulation regarding health care records of _____. I hereby approve and authorize the release as stated. I consent to the immediate release of the aforementioned records to the attorneys, claim representatives, agents and employees of each defendant listed in the caption to the foregoing stipulation.

2. AUTHORIZATION FOR RECORDS AND REPORTS. You are hereby authorized and directed to permit the examination, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by the authorized attorney, or such other person as the authorized attorney may authorize, for the purpose of legal representation, of all or any portions desired by him/her of the following:

A. Hospital records, X-rays, X-ray readings and reports, laboratory records and reports, all tests of any type, character and reports thereof, statements of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expense;

B. Medical records, including patient's record cards, X-rays, X-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, statements of charges, and any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

C. Pharmaceutical or prescription records, including statements of charges or expense.

D. The patient's records or information related to insurance, including insurance policies, insurance coverage, payment of premiums or benefits, claim file(s) and any correspondence between you and the patient or relating to the patient.

E. Any information relating to sexually transmitted diseases, mental illness, psychiatric treatment, HIV/AIDS, and/or drug/alcohol abuse, the confidentiality of which is protected by federal law, including 42 CFR, Part 2 and RCW 70.24 is excluded unless listed otherwise below.

I UNDERSTAND THAT THIS CONSENT IS TO INCLUDE DISCLOSURE OF: (PLEASE INITIAL EACH)

____ Drug/Alcohol Abuse Records ____ Sexually Transmitted Disease Information

____ HIV/ AIDS Information ____ Mental Illness or Psychiatric Records

You are further authorized and directed to furnish oral and written reports to the authorized attorney or his/her delegate, as requested by said attorney on any of the foregoing matters.

3. REQUEST FOR CONFIDENTIALITY AND REVOCATION OF PREVIOUS AUTHORIZATIONS. By reason of the fact that such information that you have acquired as my physician or surgeon is confidential to me and protected under federal and state confidentiality regulations, you are also requested to treat such information as confidential and requested not to furnish any of such information in any form to anyone, without written authorization from me. I hereby revoke any previously-dated medical waiver or authorization. **Caution: Please alert your staff to the restrictions on the release of information of any nature whatsoever regarding me to unauthorized persons.**

MY RIGHTS: I understand I am not required to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but 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. I may see and copy the information described on this form if I ask for it.

4. AUTHORIZATION FOR PHOTOGRAPHS. I also permit the authorized attorney or his/her delegate to photograph my person while I am present in any hospital.

5. DURATION OF AUTHORIZATION. This authorization shall be valid for a period of 90 days or until advised in writing by me of its revocation before 90 days from date hereof.

6. EFFECT OF A COPY. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Your full cooperation with the authorized attorney is requested.

Dated this_____ of _____ 2011..

_____

_____
(Personal Representative of the Estate of _____)