Snohomish County Sheriff's Office – Corrections Bureau

Authorization for Use and Disclosure of Health Care Information

*Inmate **Medical** Records – RCW 70.02*

Name: _____ Date of birth: _____

Address: _____

Phone: _____ Email: _____

1. My Authorization:

Snohomish County may use or disclose the following Health Care Records *(initial all that apply)***:**

_____ All health care information in my medical record for the date(s):

_____

_____ Health care information in my medical record relating to the following treatment or condition:

_____

Snohomish County may use or disclose health care information regarding testing, diagnosis, and treatment for *(initial all that apply)*:

_____ HIV (AIDS virus) _____ Sexually transmitted diseases

_____ Psychiatric disorders/mental health _____ Drug and/or alcohol use

Snohomish County may disclose the above records information to:

Name (or title) and organization: _____

Address: _____

Reason(s) for this authorization: *(initial all that apply)*

_____ At my request.

_____ Other *(specify):* _____

This authorization ends:

_____ 90 days from the date signed

_____ on _____ *(insert date)*

_____ when the following event occurs: _____
(no more than 90 days from date signed)

2. My Rights:

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment); however, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing. A revocation would not affect any actions already taken by Snohomish County based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: (1) fill out a revocation form, available from Snohomish County; or (2) write a letter requesting revocation to Snohomish County.
- I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal privacy standards.

I hereby declare under the penalty of perjury pursuant to the laws of the State of Washington that I am either the inmate or a representative of the inmate lawfully entitled to obtain records on the inmate's behalf.

_____ _____ _____

Signature of inmate or legally authorized representative | Signed in City, State | Date

_____ _____

Printed name of signatory | Relationship to inmate