Authorization to Disclose Health Information
Clinic Record
509-324-1439

Last Name:		First:		M.I.:
Date of Birth:	Social Security #:		Phone #:	
Address:	City:		State:	Zip:

Please obtain information from:

Provider/Agency: **Spokane Regional Health District; Attn: Records**		Phone#: **509-324-1439**	Fax#: **509-324-1507**
Address: **1101 W. College Avenue, RM 330**	City: **Spokane**	State: **WA**	Zip: **99201**

Please send information to:

Provider/Agency:		Phone#:	Fax#:
Address:	City:	State:	Zip:

I understand information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I authorize the following information to be disclosed:
- ☐ Immunization record
- ☐ TB test

Reason for disclosure of health information:
- ☐ At my request (Parent/Legal Guardian)
- ☐ Other: _____

Additional Patient Information:

Conditions. We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by state laws (RCW 70.02) and federal laws 42 CFR Part II.

Expiration. This authorization shall expire three hundred sixty-five (365) days from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation. You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

By signing below, you acknowledge receipt of a signed copy of this authorization.

_____ _____

Client signature (Parent or Legal Representative, if applicable) Relationship/Authority Date

_____ _____

*** I wish to withdraw this authorization:** Date