Skagit County Public Health

Jennifer Johnson, Director
Howard Leibrand, M.D., Health Officer

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Patient Name:_____ Date of Birth:_____/_____/_____

Phone:_____-_____-_____ Previous Name(s):_____

I, _____, the ☐ patient, ☐ legal next of kin or ☐ legal guardian for the patient, hereby authorize the release of the following information from the medical records of the patient named above for the time period beginning _____/_____/_____ and ending _____/_____/_____.
Date Date

INFORMATION TO BE DISCLOSED:

Please check ALL appropriate boxes:

☐ Summary of Medical History/Treatment
☐ Radiology Films
☐ General Communicable Disease
☐ Laboratory/Diagnostic Tests/COVID Test Results
☐ Radiology Reports
☐ Prenatal Records

ALL records, including any records in these subject areas:
Specific authorization for these records is required – check each box that applies.

☐ HIV/AIDS
☐ Sexually Transmitted Disease
☐ Mental Illness or Mental Health Treatment
☐ Drug & Alcohol Abuse Treatment
☐ Other:_____

I authorize that information may be ☐ RELEASED TO and/or ☐ OBTAINED FROM the following:

Name of Person/Agencies	**Address/FAX Number**
_____	_____
_____	_____
_____	_____

Staff from Skagit County Public Health may discuss my medical condition and treatment with those persons or organizations listed above.

RE-DISCLOSURE PROHIBITED: This information has been disclosed from records whose confidentiality is protected by state or federal law. These laws prohibit making any further disclosure of this information without the specific written consent of the person or guardian of person to whom it pertains, or is otherwise permitted by state law.

I release the Skagit County Public Health staff and counsel from all legal responsibility or liability that may arise from authorized release of information. I understand I may revoke this consent at any time. This consent expires on _____/_____/_____ or in ninety (90) days unless otherwise specified.

_____ Date:_____/_____/_____
Signature (Patient or person authorized to give consent)

_____ _____
Relationship if signed by someone other than patient Witness