Authorization for Release of Protected Health Information (PHI)

(Medical Authorization)

to

Skagit County Risk Management

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to Skagit County so the County can evaluate my claim for damages.

I understand that by signing this document, I authorize the release of the following information:

- Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.
- HIV test results and medical information related to HIV testing or treatment.
- Psychiatric, mental, and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment.
- Alcohol assessment, testing, referral, or treatment records.
- All other chemical dependency assessment or treatment records.
- Pharmacy prescriptions and reports.
- All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical treatment information related to alleged sexual assault or sexually transmitted disease, including test results.
- Urgent care, outpatient, or other clinic visit information.
- Gynecological and/or obstetrical information.
- All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency _____.
- Financial records related to my care and treatment.

I understand the following: (PLEASE READ AND INITIAL ALL STATEMENTS)

_____ Initial — I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____ Initial — I understand that my health information may be subject to re-disclosure by Risk Management and not protected for purposes of evaluating and investigating the claim I have filed with Skagit County .

_____ Initial — I understand that the specific information to be disclosed in my medical records may include information regarding alcohol, drug, or other controlled substance use, counseling referrals, and/or a history of testing or treatment of acquired immune deficiency syndrome.

_____ Initial — I understand that I may revoke this authorization at any time by notifying Risk Management in writing, and that the revocation will be effective as of the date Risk Management receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____ Initial — I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Risk Management.

Signature of Authorizing Individual: _____

Date of Signature: _____

Telephone number: _____

Witness (where patient is over 13 and signing the release): _____

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- ☐ Parent of minor
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other

_____

To the Provider or Records Custodian: Please send legible copies of all records to:

Skagit County Risk Management
1800 Continental Place, Suite 200
Mount Vernon, WA 98273
Fax: (360) 416-1386
email: riskmgmt@co.skagit.wa.us