



"Always working for a safer and healthier Skagit County"

# Skagit County Department of Public Health and Community Services

700 South 2<sup>nd</sup> Street, Suite #301  
Mount Vernon, WA 98273  
(360) 336-9477 Fax (360) 336-9401

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

## AUTHORIZATION FOR EXCHANGE OF INFORMATION

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Previous Name (s): \_\_\_\_\_

I, \_\_\_\_\_, the  patient,  legal 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Summary of Medical History/Treatment | <input type="checkbox"/> Radiology Reports   |
| <input type="checkbox"/> Laboratory/Diagnostic Tests          | <input type="checkbox"/> Radiology Films     |
| <input type="checkbox"/> Prenatal Records                     | <input type="checkbox"/> Immunization Record |

ALL records, including any records in these subject areas.

Specific authorization for these records is required-check each box that applies.

- |  |   |
|--|---|
| <input type="checkbox"/> HIV/AIDS                                  | <input type="checkbox"/> Drug & Alcohol Abuse Treatment |
| <input type="checkbox"/> Sexually Transmitted Disease              | <input type="checkbox"/> Other: _____                   |
| <input type="checkbox"/> Mental Illness or Mental Health Treatment |   |

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

Name of Person/Agencies

Address

_____	_____
_____	_____
_____	_____

Staff from the Department of Public Health and Community Services 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 Department of Public Health and Community Services 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 anytime. This consent expires on \_\_\_\_/\_\_\_\_/\_\_\_\_ or in ninety (90) days unless otherwise specified.

Date

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

\_\_\_\_\_  
Relationship if signed by other than patient

\_\_\_\_\_  
Witness