Skagit County Sheriff's Office- Corrections Division

Authorization for Use and Disclosure of Inmate Records Information

Inmate medical records- RCW 70.02

Name: ______________________________ Date of Birth: ________________________

Address: ____________________________ Phone: ____________________________

E-mail: ____________________________

1. **My Authorization:**

Skagit County May use or disclose the following Health Care Records (initial all that apply):

____ All my 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:
____

Skagit 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

Skagit County may disclose the above records information to:

Name (or title) and Organization: _______________________________________

Address and Phone Number: ____

Reason(s) for this authorization: ____ 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)

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 Skagit County based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, a letter must be written to Skagit County revoking authorization.
- 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 penalty of perjury 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 or inmate or legally authorized representative Signed in City, State Date

______________________________ ____________________________
Printed name of Signatory Relationship to inmate