AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Stanwood Police Department

Patient/Client name: _____ Date of birth: _____

Previous name(s): _____

My Authorization

I hereby authorize / request _____

Individual / Medical Facility

to disclose the following health care information:

All health care information in my medical, social and/or psychological record (excluding psychotherapy notes) with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital and medical records, including x-rays and other diagnostic imaging films. I also specifically authorize you to release those records relating to drugs, alcohol, HIV/AIDS, or other sexually transmitted diseases, if any.

You may disclose this health care information to:

Stanwood Police Department
PO BOX 127
Stanwood, WA 98292
Or Via FAX: 360-629-2886
Attn: _____

Reason(s) for this authorization:

☐ For use in the following criminal investigation:

Type of Investigation	
Agency Case No.	
Date of Incident/Treatment	

☐ Other: _____

This authorization ends:

☐ 90 days from the date signed
☐ on _____ (insert date)
☐ when the following event occurs: _____
(no longer 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 by providing my request to revoke, in writing, to the facility named above. A revocation would not affect any actions already taken by the facility named above based upon this authorization.
- I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by federal privacy standards.

Signature of Patient or Legally Authorized Individual | Printed Name/Relationship if signed on behalf of patient | Date

Signature of Witness | Law Enforcement Agency | Date