City of Snoqualmie – Fire Department
37600 SE Snoqualmie Parkway
Snoqualmie, WA 98065
(425) 888-1551 – Office
(425) 888-1513 - Fax

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes the City of Snoqualmie Fire Department or its staff to exchange information to the persons or organizations identified below. The City of Snoqualmie Fire Department is not obligated to honor this request unless all portions are completed.

Release of information is authorized for:

_____ _____ _____
(PRINT) Client Name | Date of Birth | Client Phone #

_____ _____ _____
Signature of Client/Guardian | Relationship | Date

Information will be disclosed to:

_____ _____
(PRINT) Client/Guardian/Agency Name | Agency Contact

_____ _____
Street Address | City, State, Zip Code

_____ _____
Phone Number | Fax Number (Optional)

Information to be released:

[ ] All medical records pertaining to an incident, which took place at _____ (time), on _____ (date),

_____ (incident location – address or nearest cross street).

Purpose for which disclosure is being made: (Please check one of the following)
[ ] Attorney (legal) [ ] Insurance [ ] Doctor [ ] Personal [ ] Other (describe) _____

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary and may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases (STD), drug and/or alcohol abuse, mental illness or psychiatric treatment.

When checked, this authorization <u>EXCLUDES</u> release of the following information:
[ ] Drug or alcohol abuse diagnosis or treatment [ ] HIV (AIDS) testing/treatment
[ ] Confirmed STD test results and/or treatment [ ] Psychiatric

This authorization will expire 90 days from the date signed.

I understand that I may revoke this authorization in writing. I understand that the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____
Client/Guardian Signature | Date

[ ] Client/Guardian refuses to sign authorization