Authorization for Release of Protected Health Information (PHI) To Cowlitz County, Washington

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

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to Cowlitz County Risk Management Committee, for purposes of processing my claim for damages filed with the Clerk of the Board, Cowlitz County Commissioners, against Cowlitz County, Washington.

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 of treatment records

- Pharmacy prescriptions and reports

- All letters and memos received or sent, including electronic mail, referencing my 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)**

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

_____ I understand that my health information may be subject to re-disclosure by Cowltiz
initials County and not protected for purposes of evaluating and investigating the claim I have filed with Cowlitz County, Washington.

_____ I understand that the specific information to be disclosed in my medical record may
initials 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.

_____ I understand that I may revoke this authorization at any time by notifying Cowlitz
initials County in writing, and that the revocation will be effective as of the date Cowlitz County 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.

_____ I understand that this Authorization for Release will expire 90 days from the date I
initials 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 by Cowlitz County.

A photocopy of this Authorization carries the same authority as the original for purposes of releasing my records to Cowlitz County, Washington.

_____ Date of Signature: _____
Signature of Authorizing Individual

Telephone number: _____

_____
Signature of 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:
The Office of Administrative Services
Risk Management Division
County Administration Building, Room 308
207 North 4th Avenue
Kelso, WA 98626