SAN JUAN COUNTY
Public Hospital District No. 1

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

STATEMENT OF EXPLANATION: Completion of this document is necessary to authorize San Juan Public Hospital District No. 1 (the "District") to release your confidential and protected health information to another person or entity as required by federal and Washington State laws concerning the privacy of such information. **FAILURE TO PROVIDE THE REQUESTED INFORMATION MAY INVALIDATE THE AUTHORIZATION AND PREVENT THE DISTRICT FROM ACTING IN RELIANCE ON THIS AUTHORIZATION.**

PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE, PASSPORT, OR OTHER FORM OF STATE OR FEDERAL PHOTO IDENTIFICATION ALONG WITH THIS FORM TO VERIFY IDENTITY.

PATIENT INFORMATION

Last Name:	**First Name:**	**Date of Birth:**
Address:	**City/State:**	**Zip Code:**
Telephone:	**Fax:**	**Email:**
Incident Dates From:	**To:**	
Facility: ☐ SJI Emergency Medical Service ☐ Village at the Harbor ☐ Village at Home		

ORGANIZATION PROVIDING INFORMATION

Name of Organization: San Juan County Public Hospital District No. 1
Address: 535 Market Street, Suite E, Friday Harbor, WA 98250

INFORMATION TO BE RELEASED

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this authorization. I hereby authorize the disclosure of the following information pertaining to the incident date above to the recipient listed below:

☐ My entire MEDICAL record and any accompanying documents.
☐ My MEDICAL record limited to: _____.

By signing this release, I specifically authorize release of information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, and chemical dependency treatment. I authorize the release or disclosure of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

Notice to those receiving information: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This protected health information is disclosed for the following purposes:

☐ Attorney / legal	☐ Insurance
☐ Continuing medical care	☐ Personal
☐ Other:	

This authorization does not apply to psychotherapy notes.

RECIPIENT RECEIVING INFORMATION

Name of Recipient:		
Address:	**City/State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**

Information used or disclosed pursuant to this authorization may be subject to further disclosure by recipients not covered by federal HIPAA regulations. Although disclosed information may no longer be subject to federal privacy protections, state law requires recipients to refrain from redisclosing such information unless another written authorization is obtained or specifically required by law.

EXPIRATION OF AUTHORIZATION

This authorization expires on: (date/event) _____. If no expiration is given, this authorization will expire ninety (90) days from the signature date below.

REVOCATION OF AUTHORIZATION

I understand that I have the right to revoke this authorization at any time except to the extent that the District has already acted in reliance on this authorization. To revoke this authorization, I understand that I must do so by submitting a written request to:

San Juan Public Hospital District No. 1
Mail: P.O. Box 370, Friday Harbor, WA 98250
In Person: 535 Market Street, Suite E, Friday Harbor, WA 98250
By Fax: (360) 378-2856

The authorization will stop on the date the request to revoke authorization is received. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.

PATIENT SIGNATURE

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that the District is prohibited from creating any conditions to treatment or payment based on me signing or not signing this authorization unless otherwise specified in this authorization. I acknowledge that I have read the provisions in this authorization and I have received a copy. I understand and agree to the terms of this authorization.

Patient Signature:	**Dated:**
Representative Name:	**Representative Signature:**
Relation to Patient	**Translator Used?** ☐ Yes ☐ No

If you are NOT the patient, but are acting on behalf of the patient, please provide your name and relation to the patient. Patient representation is acceptable ONLY if the patient is unable to make the request when given the opportunity or the patient is a minor. A representative is defined as a parent of a minor, next-of-kin, power-of-attorney, legal guardian, or the one who is legally entitled to make medical decisions on behalf of the patient. Legal representatives must provide proof of power-of-attorney or guardianship and official photographic identification for the authorization to be valid.

Parents of minors must provide proof that they have authority as the minor's representative, e.g., verification that the child is on the parent's health insurance plan as a dependent or presentation of the minor's birth certificate as well as official photographic identification such as a driver's license.

Photocopies of this authorization will be considered as valid as the original