proud past, promising future
CLARK COUNTY
WASHINGTON

Clark County Health Department
PO Box 9825 • Vancouver, WA 98666-8825
(360) 397-8000 • (360) 397-8402

AUTHORIZATION TO RELEASE INFORMATION - GENERAL

Name:_____ DOB:_____ Phone #:_____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____ FAX:_____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____ FAX:_____

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

_____ Entire Record
_____ Immunization Record
_____ Lab Test
_____ TB Test
_____ HIV Record
_____ STD Record
_____ Psychiatric/Mental Health
_____ Alcohol/Substance Abuse
_____ Billing Records
_____ Other _____
_____ Date(s)_____

REASON for disclosure of health information: (Please initial)

_____ At my request
_____ Continuing Care
_____ Legal
_____ Job
_____ School
_____ Insurance
_____ Other _____

EXPIRATION of this Authorization: (Please initial one)

_____ 90 days after signature date
_____ When this event happens: _____
_____ On this date:_____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Clark County.
- I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

_____ Date:_____
Client Signature (Parent or Legal Representative, if applicable) Relationship/Authority

*I wish to withdraw this authorization:_____ Date:_____

Witness Signature:_____

❑ Fee Explained ❑ ID Needed
❑ Pick-Up Records ❑ Mail Records ❑ FAX Records

HR-08 Rev. 04/2006
File under: CORRESPONDENCE
COPIES: White - Record Yellow – Client

Name:_____
Last First MI
DOB:_____ Sex: ❑ F ❑ M
MM/DD/YYYY
HRN:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION