SPOKANE COUNTY DETENTION SERVICES
MEDICAL/MENTAL HEALTH

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Detention Services Mental Health Department
Spokane County Detention Services
1100 W Mallon Ave Spokane, WA 99260
Office: 509-477-6686 / Fax: 509-477-6683

CCID: _____ NAME: _____ DOB: _____ SEX: ____
Last First MI

AKA: _____

I request and authorize the below named MD/clinic to release health care information for the continuity of care.

_____
MD Name/Clinic name/Attorney/Family/Other

_____
Address

_____
Phone/Fax number

This request and authorization applies to:

_____ Medication
_____ Health Care History (brief)
_____ PSYCH Eval
_____ Other:_____
_____ Treatment including treatment dates, Health conditions
_____ Tuberculosis testing, lab results, x-rays
_____ Xrays/CT scans/MRI/Specialist Reports

Purpose for which disclosure is being made (please check one of following):

☐ **Attorney** ☐ **Coordination of Care** ☐ **Doctor** ☐ **Personal** ☐ **Medical Records**

SPECIFIC CONSENT

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health and drug/alcohol abuse. You are specifically authorized to release all health care information relating to such testing, diagnosis and/or treatment of aforementioned conditions. (42 CFR, Part 2. RCW 71.34.200, RCW 70.24.105.)

This release is valid for 90 days beginning with date of signature. You may write to the Detention Services Administration to inform either that this authorization is revoked, but the revocation will not apply to information already used or disclosed.

RIGHTS OF THE PATIENT:

This authorization is voluntary; I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

SIGNED: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____