**CITY OF SUMNER**
1104 Maple Street, Suite 140
Sumner, Washington 98390-1423
253.863.6384 – Fax: 253.891.3290

Sumner Police Department
Colleen Wilson, Chief

# AUTHORIZATION FOR RELEASE OF INFORMATION

## Patient Information

Print Name of Patient________________________________________ DOB____________________

Information to be released from:__________________________________________________
Name of designated facility or provider

Address____________________________________________________________________

Information to be sent to: ___________________________________________________

Address______________________________________________Phone Number________________

## Information To Be Released

[ ] The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
[ ] All medical records
[ ] Specific Information (Please specify):

_____________________________________________________________________________

_____________________________________________________________________________

**Purpose for which disclosure is being made**: (please check the following)
[ ] Attorney [ ] Insurance [ ] Doctor [ ] Personal

**Patient Authorization:**
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* **EXCLUDE** the following information from the records released (please intital):
_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually Transmitted Disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or psychiatric diagnosis/treatment

**My Rights**
I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. 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.

Signature________________________________Relationship/Authority__________________Date_____________
(parent, guardian, or authorized representative)
(If signed by a representative, please provide description of representative's authority to act for the individual)

***This authorization will expire 90 days from the date signed***