REQUEST FOR PUBLIC RECORDS

NAME OF REQUESTER: ______________________________

ADDRESS: ______________________________

CITY: ______________ STATE ____ ZIP ______________

PHONE: ____________ DATE OF REQUEST: ________ TIME: ________

NATURE OF REQUEST:

1. Identification of records**: ______________________________

____

____

2. Inspection only _______

3. Number of copies requested _____

I declare under penalty of perjury under the laws of the State of Washington that I do not intend to use any list of individuals that may be covered by this request for commercial purposes.

Signature ______________________________

- **__**If the identified records include medical records of a District patient, you must also attach a patient authorization form. If you do not have the patient's consent, the records will be redacted unless you identify the legal basis under which patient consent is not required.__**

__FEES:__

- Standard copy charge @ $1.17 per page:

Charge _____ Pages @ $1.17 per page	$ ________
Copying charge	$ __26.00__
Total Fees:	$ ________

DOCUMENTS PROVIDED ATTACHED. ____ Faxed ____ Mailed _____ Picked Up

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For Office Use Only: **Date** _______ **Time** _______

(1) Request Granted _____ Record Withheld _____ Record Redacted _____

(2) If consent is needed, name of individual: ______________________________

(3) If withheld or redacted, identify the exemption contained in chapter 42.56 RCW or other applicable statute that authorizes the withholding of the record or part of record: ____

(4) If withheld or redacted, explain how the exemption applies: ______________________________

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: ______________________________ Date of birth: __________
Previous name(s): ____

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

☐ All Health Information in my medical record;
☐ Health Information in my medical record relating to the following treatment or condition:
____
☐ Health Information in my medical record for the date(s): ____________________
☐ Other (e.g., X rays, bills), specify date(s): ____________________

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

☐ **You may disclose this Health Information to:**

Name (or title) and organization: ______________________________
Address: ____________________ City: __________ State: _____ Zip: __________

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify) ______________________________

Authorization Expiration: *(This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)*

☐ in 90 days from the date signed
☐ on (date): ______________
☐ when the following event occurs: ______________________________
(no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
- Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________________ ______________________________
Patient or legally authorized individual signature | Date | Time

______________________________ ______________________________
Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)