AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I understand that by authorizing the release of these records I am waiving and relinquishing any privilege or right which I may have to keep said records confidential or to prevent their disclosure, and I hereby agree to hold Thurston County Fire District #6 and all of its officers, employees and agent harmless from any and all claims that may be made against them on account of the release of the below-described records as herein authorized.

FOR DISTRICT USE ONLY

Date:	Time: AM PM
Request No.	
Received by:	

PATIENT

Name ____ SSN ____ Date of Birth ____

Address ____ Phone ____ Driver's License No. ____

City ____ State ____ Zip ____ Previous Name, if any ____

I request and authorize Thurston County Fire District #6 to release health care information of the patient above to:

RELEASE TO

Name ____ Phone ____ Fax ____

Affiliation ____ E-mail Address ____

Address ____ City ____ State ____ Zip ____

This request and authorization applies to:

- ☐ All health care information
- ☐ Health care information relating to the following treatment, condition or dates of treatment
- ☐ Other:

Date of incident: ____

Time of incident: ____ AM PM

Address/Location of incident: ____

Other Details:

RELEASE REQUIRING ADDITIONAL, SPECIFIC CONSENT:

I understand my **initials** and **signature** below **authorize the release** of healthcare information relating to testing, diagnosis or treatment for:

____ (Initial) HIV/AIDS
____ (Initial) Mental Health
____ (Initial) Sexually Transmitted Diseases
____ (Initial) Substance Abuse
____ (Initial) Reproductive Care (minors only)

Minors – *A minor's patient signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older); (2) alcohol and/or drug abuse (age 13 and older); and (3) mental health conditions (age 13 and older).*

Date ____ Signature of patient or patient's authorized representative ____ Relationship to patient ____ ☐ Check if patient is a minor

Signature of patient or patient's authorized representative:	**Date:**

Relationship/status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Recipient's Signature:	Date of Receipt:	Time of Receipt: AM PM

District Representative: ____ Date: ____ Number of copies: ____

Proof of Washington State Driver's License was received\checked W.D.L No.:

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Thurston County Fire District #6
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Office Hours: 8:00 a.m. - 12:00 p.m. and from 1:00 p.m.-4:30 p.m. Monday – Friday, Excluding Legal Holidays