Pierce County Sheriff's Department—Corrections

Authorization for Release of Inmate Healthcare Records

Inmate Medical Records—RCW 70.02

Full Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

My Authorization:

Pierce County may disclose the following healthcare records:

All healthcare information in my medical file for the following date(s):

_____

Only the healthcare information in my medical file relating to the following treatment or condition:

_____

Pierce County may disclose healthcare information regarding testing, diagnosis, and treatment for *(initial all that apply)***:**

_____ HIV (AIDS virus)

_____ Sexually transmitted diseases

_____ Psychiatric disorders/mental health

_____ Drug and/or alcohol use

These records may be released to:

Name or organization:_____

Address: _____

This authorization ends: _____ 90 days from date signed

_____ on _____ *(insert date)*

_____ when the following occurs: _____

(no more than 90 days from date signed)

I hereby declare under the penalty of perjury pursuant to the laws of the State of Washington, that I am either the inmate or a representative of the inmate, lawfully entitled to obtain records on the inmate's behalf.

_____ _____

Signature of inmate or legally authorized representative **Date**

_____ _____

Printed name **Relationship to inmate**

_____

Office Use Only (ID of inmate or representative)

Form Date: 3/7/17