Clark County Public Health
P.O. Box 9825 ● Vancouver, WA 98666-8825
Phone (564) 397-8000

◯(564) 397-8091 fax-Administration
◯(564) 397-8080 fax-Infectious Disease
◯(564) 397-8442 fax-Healthy Families

RELEASE OF INFORMATION

Name:__________________________ DOB:______________ Phone: ______________ CCPH HRN NO.______________

RECORDS FROM:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip

____
Phone Fax

RECORDS TO:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip

____
Phone Fax

I AUTHORIZE the following information to be disclosed (*please check all that apply*):

☐ Complete Medical Record including progress reports ☐ Lab Test ☐ Imaging ☐ Billing records ☐ Treatment

Other/Specify: ____

The following items are specially protected under federal regulations and require specific authorization.
Please initial:

_________ STD Record _________ HIV Record _________ Substance Use _________ Mental Health

EXPIRATION of this Authorization (*please initial one*):

☐ 90 days after date of signature ☐ On this date:____________________

☐ When this event happens (*must be related to reason for disclosure*): ____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Clark County.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

____ Date: ______________
Client Signature (*Parent or Legal Representative, if applicable*) **Relationship/Authority**

*I wish to withdraw this authorization:____ Date: ______________

Interpreter's Statement:
By my signature below, I attest I have explained the information on this form fully to the client.

Interpreter Signature:______________________________ Printed Name: ____________________________ Date:___________

Organization: ____________________________________