



Yakima County Department of Corrections

Authorization for Use and Disclosure of Health Care Information

Inmate Medical Records – RCW 70.02

Name: _____ Date of birth: _____
Address: _____
Phone: _____ Email: _____

1. My Authorization:

Yakima County may use or disclose the following Health Care Records *(initial all that apply):*

_____ All health care information in my medical record for the date(s):

_____ Health care information in my medical record relating to the following treatment or condition:

Yakima County may use or disclose health care 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

Yakima County may disclose the above records information to:

Name (or title) and organization: _____
Address: _____

Reason(s) for this authorization: _____ At my request.
(initial all that apply) _____ Other *(specify):* _____

This authorization ends: _____ 90 days from the date signed
_____ on _____ *(insert date)*
_____ when the following event occurs: _____
(no more than 90 days from date signed)

2. My Rights:

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment); however, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing. A revocation would not affect any actions already taken by Yakima County based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: (1) fill out a revocation form, available from Yakima County; or (2) write a letter requesting revocation to Yakima County.
- I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal privacy standards.

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 Signed in City, State Date

Printed name of signatory Relationship to inmate