Authorization to Release Healthcare Information

Requestor: *Please complete this form and submit to:*

Public Records Officer
Lacey Fire District 3
1231 Franz St SE
Lacey, WA 98503-2412

Patient Name	Date of Birth
Name at time of incident (if different)	Daytime Phone

I request/authorize Lacey Fire District Three to release healthcare information of the patient above to:

RELEASE TO			
	Name		
	Affiliation		Phone
	Address		FAX
	City	State	Zip
	Email Address		

For Incident Report: (Please provide as much ***specific information*** as possible)

Date/Time of Incident: _____

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 patient's 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.)	

District Representative:	Date Completed:

THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE SIGNED