Whatcom County Health Department
1500 N. State Street Bellingham, WA 98225

Authorization for Use and Disclosure of Health Information

Client Name (Last)_____(First)_____(Middle)_____
(Type or Print)

Date of Birth_____ Health Department Client #_____

☐ I authorize Exchange of Health Information between Whatcom County Health Department and the following parties:

☐ Name_____	☐ Name_____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____

Fill out addendum to exchange information with additional parties if necessary

Information to be disclosed:

☐ All health care information (see *Authorization to Disclose* section below for federally protected information)

☐ The following specific information only_____

Authorization to disclose:
We need your consent to release your health information to someone else. In addition, we need special consent to release your information about mental health, drug or alcohol use, HIV/AIDS, or sexually transmitted diseases. NONE of the information below can be released without your initials. When you write your initials next to an item, you are giving permission for this information to be released.

_____ Sexually Transmitted Diseases _____ Drug and Alcohol _____ HIV/AIDS _____ Mental Health

Purpose of disclosure: _____

Requested by: (person requesting information)_____

Expiration of authorization
This authorization is effective through _____(date) unless you or your personal representative cancel it.

Right to cancel
You may cancel this authorization by submitting a written request to Whatcom County Health Department.
Call (360) 778-6100 if you need more information

You may refuse to sign this authorization. You can still receive services from Whatcom County Health Department if you do not sign.

I authorize disclosure:

☐ Client ☐ Parent/Guardian ☐ Personal Representative (specify authority)_____

Signature_____ Date_____

Re-disclosure prohibited: We cannot guarantee that the recipient of this information will not give it to someone else. However, state and federal law say information in your health record must stay confidential. Your written permission is required for disclosure except as otherwise permitted by law.

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Addendum

Client Name (Last)_____(First)_____(Middle)_____
(Type or Print)

Date of Birth_____ Health Department Client #_____

To request information to or from additional parties, complete the following and attach to original authorization.

☐ I authorize Exchange of Health Information between Whatcom County Health Department and the following additional parties:

Name_____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____

Name_____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____

Name_____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____

Please sign below to indicate your consent to the release of Information to or from these additional parties.

☐ Client ☐ Parent/Guardian ☐ Personal Representative (specify authority)_____

Signature_____ Date_____