Jefferson County Fire Protection District No. 2
Quilcene Fire Rescue

MEDICAL RELEASE FORM

Administration – 61 Herbert St
Station 21 – 70 Herbert St
Mailing – PO Box 433
Quilcene, WA 98376
Phone (360) 765-3333

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Please mail request to **PO Box 433, Quilcene, WA 98376** or e-mail to **districtsecretary@qfr2.org**

Patient Name: _____ **Date of Birth**: _____

I request and hereby authorize Jefferson County Fire Protection District No. 2 dba Quilcene Fire Rescue to release the following protected healthcare information that it maintains involving me:

_____ ☐ All **Patient Care Records**, or
Patient Initials

_____ ☐ Only **Patient Care Records** from date of call/treatment: _____
Patient Initials

Where do the records need to go?

_____ _____
Please Print the Name of the Individual or Agency Requesting the Records **Phone Number**

_____
Mailing address

_____ _____ _____
City **State** **Zip Code**

_____ _____
Email address **Fax number**

How would you like to receive the records? (choose and initial one)

_____ ☐ **Mail** I want the records to be mailed to the above address.
Patient Initials

_____ ☐ **Email** I want the records to be emailed to the above email address.
Patient Initials *Records will be in a password protected PDF attachment*

_____ ☐ **Fax** I want the records to be faxed to the above fax number.
Patient Initials

_____ ☐ **In Person** I want to ☐ receive a copy of the records (or) ☐ inspect the records in person.
Patient Initials

PUBLIC DISCLOSURE NOTICE: Information contained in any communication to or from Jefferson County Fire Protection District No. 2 dba Quilcene Fire Rescue, including attachments, may be subject to the disclosure requirements of Washington's Public Records Act, Ch. 42.56 RCW.

This authorization to release protected healthcare information will expire within 90 days from the date of signature or I may revoke this authorization in writing at any time. I understand that a revocation will not apply to records already disclosed in response to this authorization. I understand that Jefferson County Fire Protection District No. 2 dba Quilcene Fire Rescue has no control over records that have been disclosed to a third party in response to this authorization. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic information. I give my specific authorization for these records to be released.

OR exclude the following information from the records released. Initial each that should not be released:

_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually Transmitted Disease _____HIV/AIDS diagnosis/treatment/testing

_____Mental Illness or Psychiatric Diagnosis/Treatment _____Genetic Information

_____ _____ _____/_____/_____
Signature Print the name of who signed. Date

Signer is: ☐ Patient ☐ Parent ☐ *Legal Guardian ☐ *Authorized Representative **Provide documents to prove authority to sign on behalf of the patient*