

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Information to be disclosed FROM:

Glaucus Peak High School  
Name of designated Facility and/or Health Care Provider

Address

City, State, Zip Code

Phone Number

Fax Number

Information to be disclosed TO:

Snohomish County Public Defender Association  
2722 Colby Avenue, Suite 200  
Everett, WA 98201 Phone: 425-339-6300 Fax: 425-339-6363

This disclosure is being made for the purposes of Legal Representation.

I hereby request that the following information be released:

Any and all information (chart notes, labs, x-rays, special tests) regarding my treatment on:

Month/Day/Year

**DISCLOSURE OF SENSITIVE INFORMATION:** I understand that my records may contain sensitive information regarding the diagnosis and/or treatment of HIV/AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness, psychiatric treatment, and sexual assault/abuse.

I give my specific authorization for release of my records containing the following information: (initial all that apply)

Drug/Alcohol abuse/treatment & diagnosis  
HIV/AIDS diagnosis/treatment/testing  
Mental Illness or Psychiatric  
diagnosis/treatment/testing

Sexually Transmitted Disease  
Sexual Assault/Abuse

## My Rights:

- (1) I understand I do not have to sign this authorization in order to obtain health care benefits.
- (2) I may revoke this authorization in writing at any time. However, I understand that any information released prior to my revocation of this authorization cannot be recalled.
- (3) I understand that my records may contain information related to mental health issues (per RCW 71.05.390) and or substance use disorders (42 CFR Section 2). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent.
- (4) I understand that information I have authorized to be disclosed may be re-disclosed, consistent with the scope of legal representation at which time it may no longer be protected under Federal Privacy Laws.

This authorization will expire one year from date signed.

SIGNATURE: X

DATE: 9/16/21

Month/Day/Year