INFORMED CONSENT AND AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION (HIPAA COMPLIANT)

Patient/Client Information:

Name: Michael-Kay'Shaun Eslava DOB: 2-13-03 SSN: _____

Information to be released from:

Snohomish School District

Name of Designated Agency, Individual or Provider

Address

360-563-7279.

Telephone Number Fax Number

Information to be released to:

Attorney:

Law Offices of Vanessa C. Martin

Attorney Name and/or Agency (and any agents, designees or representatives)

1425 Broadway #412, Seattle WA 98122

Address

206-325-8792 206-260-8999

Telephone Number Fax Number

Investigator (may also discuss/request info):

Meredith Hailey / MKH Investigations

Investigator Name and/or Agency

PO Box 404 Burien, WA 98062

Address

(206) 295-7298

Telephone Number Fax Number

Information to be released and/or discussed:

- [x] All of my health information and/or records maintained by the above-named institution/individual
- [ ] All dictations (discharge, summary, ER, office visits, history & physical, consults, operative) and all diagnostic studies/results
- [ ] Medical records, evaluations and summaries of treatment
- [ ] Copies of X-rays and/or photographs
- [ ] Psychological testing and/or psychiatric evaluation records
- [ ] Intake/treatment summaries
- [ ] Progress notes
- [x] Educational records and/or transcripts
- [ ] Health information and/or records for the following date(s):
- [x] Consult with attorney/investigator (if necessary/as needed)
- [x] Other: evaluations, counseling, SPED records.

Thank you!

Patient/Client Authorization:

I understand this authorization extends to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, HIV, substance abuse or mental health conditions.

I understand that the above medical information may be subject to re-disclosure and may not be protected under state and federal laws protecting health care information unless protected by specific statutes protecting more sensitive information (e.g. 42 CFR Part 2 for alcohol and drug treatment records, Ch. 70.24 RCW for HIV/STD/AIDS information).

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Disclosure of this information is for legal representation and is at my request.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released.

Unless cancelled earlier by me, this authorization will expire **one year** from the signature date or on _____.

A copy or fax shall be considered valid in lieu of the original.

Signature: x MKEslava Date: 6-18-21

(Patient/Client, Guardian or Authorized Representative)

Witness: Vanessa C Martin Date: 6-18-21