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Statutory Provisions that may affect the disclosure of records

(These are the provisions most commonly encountered by the District. A full list of other statutes can be found on the Washington State Attorney General's website at http://www.atg.wa.gov/sunshine-committee.)

RCW 5.60.060 .....Attorney Client Privilege
RCW 10.52.100 .....Records identifying child victim of sexual assault
RCW 18.71.0195 .....Medical Disciplinary Reports
RCW 19.34.240(3) .....Private digital signature keys
RCW 26.12.170 .....Reports of child abuse/neglect with courts
Ch. 26.23 RCW .....Domestic Relations –State Support Registry
RCW 26.44.010 .....Privacy of reports on child abuse and neglect
RCW 26.44.020(19) .....Unfounded allegations of child abuse or neglect
RCW 26.44.030 .....Reports of child abuse/neglect
Ch.40.14 RCW .....Preservation and destruction of public records
Ch.40.24 .....Address confidentiality for victims of domestic violence, sexual assault, and stalking
RCW 42.23.070(4) .....Municipal officer disclosure of confidential information prohibited
RCW 42.41.030(7) .....Identity of local government whistleblower
RCW 42.41.045 .....Non-disclosure of protected information (whistleblower)
RCW 43.43.830 -.840 .....Background Checks
RCW 48.62.101 .....Local government insurance transactions
Ch. 49.17 RCW.....Washington Industrial Safety and Health Act
RCW 50.13.060 .....Access to employment security records by local government
RCW 51.28.070 .....Worker's compensation records
RCW 51.36.060 .....Physician information on injured workers
RCW 51.48.040 .....Inspection of Employer Records by L&I
RCW 70.24.105 .....HIV/STD records
RCW 70.96A.150 .....Alcohol and drug abuse treatment programs
RCW 71.05.390 .....Mental health records.
RCW 74.20.280 .....Child support enforcement
RCW 74.34.095 .....Abuse of vulnerable adults
RCW 82.32.330 .....Disclosure of tax information
42 USC 290dd-2 .....Confidentiality of Substance Abuse Records
42 USC Sec. 12101 et. seq.....Americans with Disabilities Act
29 USC Sec 657 et seq.....Occupational Safety and Health Act

Most of the Federal or State agencies that administer the above acts have adopted regulations to implement the acts. The regulations must be reviewed together with the acts when reviewing record requests.

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REQUEST FOR PUBLIC RECORDS

NAME OF REQUESTER:_____

ADDRESS: _____

CITY: _____ STATE ____ ZIP _____

PHONE: _____ DATE OF REQUEST: _____ TIME: _____

NATURE OF REQUEST:

1. Identification of records*: _____

_____

_____

2. Inspection only _____

3. Number of copies requested _____

I declare under penalty of perjury under the laws of the State of Washington that I do not intend to use any list of individuals that may be covered by this request for commercial purposes.

Signature _____

*If the identified records include medical records of a District patient, you must also attach a patient authorization form. If you do not have the patient's consent, the records will be redacted unless you identify the legal basis under which patient consent is not required.

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For Office Use Only: Date _____ Time _____

(1) Request Granted _____ Record Withheld _____ Record Redacted _____

(2) If consent is needed, name of individual: _____

(3) If withheld or redacted, identify the exemption contained in chapter 42.56 RCW or other applicable statute that authorizes the withholding of the record or part of record:

_____

(4) If withheld or redacted, explain how the exemption applies to the record withheld:

_____

Signature: _____

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth:_____
Previous name(s):_____

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

☐ All Health Information in my medical record;
☐ Health Information in my medical record relating to the following treatment or condition:
_____
☐ Health Information in my medical record for the date(s): _____
☐ Other (e.g., X rays, bills), specify date(s):_____

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

☐ **You may disclose this Health Information to:**

Name (or title) and organization: _____
Address: _____ City: _____ State:_____ Zip: _____

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify) _____

Authorization Expiration: *(This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)*

☐ in 90 days from the date signed
☐ on (date): _____
☐ when the following event occurs: _____
(no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.
Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
- Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)