Authorization to Obtain/Release Confidential Information

HIV/STD Program Services

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

(253) 649-1418 (ph.) (253) 649-1358 (fax)

I, _____, authorize Tacoma-Pierce County Health Department HIV/STD Program Services to discuss my care with the following parties in an effort to access and coordinate needed services.

_____

(Name of person or organization to which disclosure is to be made)

Initial highlighted areas below:

_____ Discuss disclose my HIV status/results.
_____ Discuss my GC infection.
_____ Discuss my CT infection.
_____ Other (specify) _____

_____ Discuss my Syphilis infection.
_____ Release all records relating to HIV/AIDS or STD.
_____ Release PrEP labs. (Hep B and Creatinine)
_____ Hep C labs.

Initial highlighted areas below:

The purpose of the disclosure and/or exchange of information is to:

_____ Doctor (name)
_____ Pierce County AIDS Foundation (PCAF)
_____ Community Health Care
_____ At my request

Contact Person

Name _____

_____

Address _____

Phone _____ Fax _____

☐ Leave a message at this phone number: _____

☐ Send an email to the following address: _____

I understand I do not have to sign this authorization in order to get health care benefits.

If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations or other law. Federal rules prohibit any further disclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that my records and all confidential information about any individual with a reportable disease or condition shall be protected by persons with knowledge of such identity and confidentiality will be maintained in accordance with WAC 246-100-016.

This consent will expire in one year or upon the expiration date stated below (whichever comes first). The expiration date of this consent must last no longer than reasonably necessary to serve the purpose for which it is given and term at end of service noted.

Patient Signature: _____ Authorization Date: _____

Expiration Date (if applicable): _____ Witness: _____