Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:

(Name, DOC#, DOB)

HEALTH INFORMATION DISCLOSURE

RELEASED BY (DOC EMPLOYEE/CONTRACT STAFF NAME/TITLE)	DATE	TIME	REFERENCE #

RELEASE TO (REQUESTER'S NAME/TITLE)	
REQUESTER'S ADDRESS	REQUESTER'S TELEPHONE

Reason health information was reviewed/released:

If health information was released via copies/fax, state inclusive dates, consultations, reports, etc.:

If health information was verbally released, state what information was provided:

Health information was release by (check as applicable):

☐ Copies ☐ Fax ☐ Review ☐ Scan/E-mail ☐ Telephone ☐ Verbal

SIGNATURE – CHECK APPROPRIATE BOX: ☐ Signature of patient receiving information **OR**
☐ Signature and stamp of person disclosing information

DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.