|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_ Police DepartmentConsent for Release of Medical Information | Police case no.Court case no. |

# I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as:

### (Person Authorizing Consent)

(check one)Patient Patient's Authorized Representative Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby authorize Hospital/Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and/or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fire Department/EMS

to release the following medical records information of: \_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_,

for the time period beginning and ending at the conclusion of criminal legal case(s) above.

### **ALL INFORMATION TO BE RELEASED, INCLUDING THE FOLLOWING:**

|  |  |
| --- | --- |
| SUMMARY OF MEDICAL HISTORY/TREATMENTADVANCE NOTICE OF DISCHARGE DATE/TIME ONLYRADIOLOGY RECORDS AND FILMSPROGRESS NOTESOPERATIVE/PROCEDURE NOTESEMS / PARAMEDIC RECORDSTESTING and/or TREATMENT FOR SEXUALLY TRANSMITTED DISEASES, AIDS, OR HIV INFECTION | LABORATORY / DIAGNOSTIC TESTS / REPORTNURSING / SOCIAL WORK NOTESEMERGENCY ROOM RECORDSCONSULTATIONSSANE and/or FNE REPORTS (including digital photographs)TESTING and/or TREATMENT FOR ALCOHOL and/or DRUG ABUSE AND MENTAL HEALTH CONDITIONSOTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**The above indicated health information shall be released to:**

Investigating Officer or their designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Police Department, address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) Fax: ( ) Email:

I understand:

1. The purpose of this disclosure is to assist in a criminal investigation and/or prosecution and may need to be disclosed to the prosecutors and defense attorneys involved in the investigation.
2. I hereby request and grant permission to the EMS facility and staff, medical facility, any attending physicians, nurses and other staff, to release to officers of the Police Department above, and/or the offices of the King County Prosecuting Attorney, and/or the offices of the City Prosecutor, a completed copy of all records requested above. Medical facility and EMS staff may discuss my medical condition and treatment with the assigned detective or their designee, the King County Prosecutor’s Office, or the City Prosecutor’s Office, the assigned defense attorney and/or their designee (with a prosecutor present) and testify in court as to the same.
3. I understand that my medical care (treatment, payment, or enrollment) is not conditioned on my signing this authorization.
4. Once disclosed, the recipient may not be required to maintain the confidentiality of the health care information. However, I understand that certain health care information may be protected under State and Federal Law (42 CFR Part 2 and RCW 70.24).
5. This authorization **expires at the conclusion of the case noted at the top of the form**, unless sooner revoked by me in writing.
6. A photocopy of this authorization shall have the same effect as the original.

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**Signature of Victim/Patient Date Signature of Authorized Representative Date**

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**Signature of Witness/Translator Date Reporting Officer Serial Number**