Medical Waiver & Release of Liability Form

TULALIP POLICE DEPARTMENT • 6332 31st Ave NE, Suite A • Tulalip, WA 98271 • 360-716-4608

I, _____, am voluntarily giving written consent for the Tulalip Police Department to obtain the following medical information:

☐ The most recent 2 years of pertinent information (charts, notes, labs, x-rays & tests)

☐ Any and all medical records on file with the below mentioned medical facility

☐ Specific information (please specify): _____

☐ Purpose ☐ LE ☐ Attorney ☐ Personal

I also understand that any/all records that are obtained by this agency may be used against me in Criminal or Civil proceedings held in any State, Federal or Tribal Court.

PATIENT AUTHORIZATION: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I do hereby give my specific authorization for these records to be released as well (including all abuse, treatment, testing and/or diagnosis).

☐ Drug/Alcohol ☐ HIV/AIDS ☐ Sexually Transmitted Disease

☐ Mental Illness ☐ Sexual Assault Kit ☐ SANE (Sexual Assault Nurses Exam)

The Tulalip Police Department, Tulalip Tribes, or their Agent, Officials, or any other Agency assisting the Tulalip Tribes in this matter/incident shall not be held liable for any outcome of the Medical Release and/or investigate information released herein.

Date of Incident: _____ Type of Incident: _____

Location of Incident: _____

TPD Case Number: _____ Other: _____

Patient Name: _____ DOB: _____ Phone: _____

Home Address: _____

Identification Number: _____ Type (State/Tribe): _____

Name of Facility Releasing Information

Facility Name: _____ Phone: _____

Mailing Address: _____

MY RIGHTS: I understand I do not have to sign this authorization in order to obtain healthcare (treatment, payment, or enrollment), I may revoke this authorization in writing. 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 from. I further understand that once the health information I have authorized to be disclosed reaches the noted recipient (Tulalip Police Department), that person or organization mayre-disclose it, at which time it may no longer be protected under such Privacy Laws as referenced herein.
This medical release expires 90 days from the date signed.

_____ _____ / _____

Patient, Guardian, Authorized Representative Signature | Date/Time | Date Expires