Community Integrated Health Services

Authorization and Consent to Disclose Mental Health and/or Substance Use Disorder (SUD) Protected Health Information (PHI)

Under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 & 164, a health care provider or agency can use and share most of your private health information (PHI) in order to provide treatment, manage and coordinate your care as well as to receive payment for that care.

Under federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, the disclosure and use of PHI related to a diagnosis, treatment or referral for treatment or identification as having a SUD, is more restricted than under HIPAA. Except for certain recognized exceptions this disclosure requires your consent. This consent must be in writing.

PRIOR TO RELEASING ANY INFORMATION, ENSURE ROI HAS NOT BEEN REVOKED (SEE REVOCATION SECTION BELOW)

Authorization to Disclose or Exchange Information of:	
Name (first, middle, last) / Avatar ID#	Date of Birth
(Additional Information that may be helpful in locating records)	
Former Names	

Consent To Share Information: You can consent to share all of this information or just some information.

Use this form to provide your consent for sharing specific types of information. Please initial next to each program type for which you authorize the release of information

- _____Mental health services
- _____Referrals and treatment for an alcohol or substance disorder

Information to be disclosed, shared and/or exchanged (initial each one that applies):

_____ Progress Notes/Reports
_____ Psychological Test Results/Evaluation
_____ Psychiatric Evaluation
_____ Medication/Lab Reports
_____ Assessment/Diagnosis
_____ Treatment Plan
_____ Alcohol and Drug use
_____ Discharge Reports
_____ HIV/AIDS and STD results, diagnosis or treatment (RCW 70.02.220)

_____ Other (please specify): _____

I understand that my care providers will provide and coordinate aspects of my care and treatment and will therefore need to share certain PHI about my referral, diagnosis and/or treatment for substance use disorder [and mental health] with my: 1) treatment team; 2) other treating providers; 3) other individuals or entities involved in my care and/or recovery; 4) entities responsible for payment and 5) others listed below as authorized by me or by law.

By signing this form I understand:

- I am giving consent to share and disclose my MENTAL HEALTH and/or SUBSTANCE USE DISORDER INFORMATION AS INITIALED ABOVE.
- My information may be shared only among each agency and person listed below but is still limited to a stated purpose and "need to know" standard.
- My information will be shared to help diagnose, treat, manage, coordinate care and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health, substance use, or medical treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically.
- The sharing of my health information will follow state and federal laws.
- This form does NOT give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information shared with or disclosed in reliance upon my consent cannot be taken back. Upon request I can inspect or obtain a copy of information I have authorized to be released.
- I will notify Community Integrated Health Services in writing when I want to withdraw my consent.
- I can have a copy of this form.

Duration of Disclosure:

My consent will expire on the following date, event or condition unless I withdraw my consent: _____.

(If expiration date is left blank, the consent will expire one year from the signature date.)

Disclose to and Exchange Information with:		
The following treating health care providers, entities, and individuals with whom information about my care can be shared include:		
Name (first, middle, last) & Title	Org./Business Name *(If applicable)*	☐ Treating Provider ☐ Community Care Agency/Non-treating provider
Address (street, city, state, zip code)		
Phone (include area code)	Purpose for disclosure **(required)**	

Method of Disclosure / How Information May be Shared

Please indicate how you authorize your information to be shared (initial all that apply):

_____ **Verbal Communication** (allows for verbal communication only related to information initialed above)

_____ **Written correspondence** (allows for access to printed information related to information initialed above)

Authorization:

- I understand that I must voluntarily and knowingly sign this authorization before any of my behavioral health, mental health or substance use disorder information can be released and that I may refuse to sign in which event the information will not be released.
- I have read this form or have had it read to me and I understand it. I have had my questions about this form answered.
- By signing below, I authorize the above provider organizations, Community Integrated Health Services, and the other identified providers, non-provider entities and individuals to communicate with, disclose and re-disclose among themselves my PHI as described herein.

Signature	Date	Telephone number
Print Name	Witness/Notary (sign and print name if applicable)	

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of Minor ☐ Legal Guardian ☐ Personal Representative ☐ Other

Revocation:

USED ONLY TO REVOKE CONSENT

- I hereby revoke the above consent, recognizing action may have already taken place in accordance with this consent, for which I hold the above parties harmless.

Signature: _____ Date: _____

All disclosures must be accompanied by the following notice: "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 medical 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."

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Peer Bridgers Fax: 360-719-1208 or 844-810-6423
Trueblood Fax: 360-356-1832 or 844-810-6422
WISe Fax: 360-558-7189 or 844-497-2430