AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **Date of Birth:** _____

I authorize the provider checked below to: ☐ SEND my behavioral health information / records ☐ Request records / information FROM ☐ Exchange information VERBALLY

☐ MultiCare Outpatient Behavioral Health (mental health)
☐ MultiCare Behavioral Health Substance Use Disorder Program
☐ Navos Outpatient Mental Health
☐ Navos Psychiatric Hospital
☐ Greater Lakes Outpatient Mental Health
☐ Greater Lakes Substance Use Disorder Program
☐ Navos Substance Use Disorder Program
☐ Navos Sunstone CLIP
☐ Greater Lakes Recovery Center (E&T)

To/from the following provider/Person: Relationship to client: _____

Name: _____ Phone #: _____

Address: _____ FAX #: _____

City/zip _____ Email: _____

Type of Information to be disclosed / requested:

☐ Progress Notes ☐ Medication Prog Notes ☐ Medication Assessment ☐ Medication Listing ☐ Initial Assessment
☐ Treatment Plan / Summary ☐ Crisis Plan ☐ Lab results ☐ UA Lab results ☐ Discharge Summary
☐ Appointment Verification ☐ Summary of treatment, attendance, compliance / monthly status reports ☐ Scheduling and Appointment information ☐ Financial / demographic info

☐ School records/IEP ☐ All records ☐ Other: _____

Timeframe of information: ☐ Most recent document ☐ Current treatment episode ☐ All treatment episodes

☐ Other – from _____ to _____

Purpose for Release of information is for CONTINUITY OF CARE unless otherwise specified below:

☐ Legal ☐ Personal Use ☐ Financial ☐ Housing ☐ Other: _____

- I understand that alcohol and/or drug abuse treatment records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and HIPAA (45 CFR, Parts 160 and 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. By selecting the provider above, I give my specific consent to use/disclose this information.
- I understand that my mental health records are protected under Washington State Law (RCW 70.02) and HIPAA (45 CFR Parts 160 and 164) and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that if there is information related to alcohol or drug use included in my mental health record, this information will be included in the use/disclosure unless specifically excluded below. By selecting the provider above, I give my specific consent to use/disclose this information.
- I understand that my alcohol/drug abuse treatment records and/or mental health records may include information related to the testing, diagnosis and treatment of HIV/AIDs/Sexually Transmitted Diseases (STDs). I authorize the disclosure of this information as well if not specifically excluded below.

  List the exclusion here: _____
- I understand that the information disclosed may be subject to re-disclosure by the intended recipient and may no longer be protected by federal privacy laws or regulations.

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- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the agency checked above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.
- I understand authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment, payment on my behalf unless an authorization for disclosure is required in order to receive third party payment for substance use disorder treatment services rendered.
- A copy or fax of this document shall be considered valid in lieu of the original.
- I understand that there may be a fee charged for copies of my records.

EXPIRATION - Active Clients: This authorization expires 30 days after termination of services unless otherwise specified below.

Alternate expiration date / closed clients: This authorization is valid only until the date or event specified in this section, otherwise will expire 90 days from the signature date. ☐ Specific Date/event: _____

_____ _____

Signature (client 13 or older or legal representative) Date

Relationship to client: ☐ Client ☐ Parent ☐ * Legal Representative – **Documentation required**

Printed Name of Legal Representative: _____

MultiCare Behavioral Health
325 East Pioneer
Puyallup, WA 98372
Health Information/Medical Records Department

- Phone: 253-697-8530
- Fax: 253-697-8393
- Email address to request a blank ROI/send a completed ROI to HIM Dept. bhmedicalrecords@multicare.org
- Website: www.multicare.org/behavioral-health (ROI form available on the website for download)

Greater Lakes Mental Healthcare
9330 59th Ave. SW
Lakewood, WA 98499
Health Information/Medical Records Department

- Phone 253-620-5150
- Fax: 253-620-5008
- Website: www.glmhc.org (ROI form available on the website for download)

Navos Mental Health and Wellness Center
1210 SW 136th Street
Burien, WA 98166
Health Information/Medical Records Department

- Outpatient Mental Health, Substance Use Disorder Treatment, Sunstone Medical Records Requests
  - Phone: 206-257-6609
  - Fax: 206-257-6830
- Navos Hospital Medical Records Requests
  - Phone: 206-257-6736
  - Fax: 206-257-6836
  - Website: www.navos.org (ROI form available on the website for download)