AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

navos™
Healthy Mind. Healthy Body. Healthy Community.

Client Name: _____
Date of Birth: _____ **Client MRN:** _____
Case Manager Name: _____

☐ **Navos Outpatient Services – MHWC**
1210 SW 136th Street
Burien, WA 98166
Phone: (206) 257-6609
Fax: (206) 257-6830

☐ **Navos Inpatient Services – Hospital**
2600 SW Holden Street
Seattle, WA 98126
2nd Floor Fax: (206) 933-7250
3rd Floor Fax: (206) 933-7201

INFORMATION TO BE DISCLOSED OR REQUESTED

☐ **Disclose information to:** ☐ **Obtain information from:** **Method of release:** ☐ Exchange ☐ Verbal ☐ Written Records

I authorize the person or organization named below to disclose information to Navos

Name: _____ Address: _____
Organization: _____ Telephone: _____ Fax: _____

INFORMATION REQUESTED FROM OTHER SOURCES:

☐ Lab Results
☐ Medical Information
☐ Records of hospitalizations
☐ Current School Records
☐ Psychiatric Information
☐ Mental Health Information
☐ Substance Use Assessment/Treatment Records
☐ Other (specify): _____

INFORMATION TO BE DISCLOSED BY NAVOS: (Initial any checked categories)

____ ☐ All Medical Records
____ ☐ All Medical Records from date _____ to date _____
____ ☐ Psychiatric Information (if written records are disclosed, includes current prescribed medication, the most recent psychiatric evaluation, and psychiatric medical notes for the past 6 months)
____ ☐ Other Mental Health Information (if written records are disclosed, includes the current treatment plan, and individual or group progress notes for the past 6 months)
____ ☐ Case Management Services
____ ☐ Treatment Goals and/or Progress
____ ☐ School Attendance/Records
____ ☐ Verification of completion of services/hours
____ ☐ Assessment Results and Recommendations
____ ☐ SUD Assessment Results and Recommendations
____ ☐ Attendance in Services
____ ☐ Lab/UA Results
____ ☐ Discharge Summaries and Recommendations
____ ☐ Monthly Status Reports
____ ☐ Other: _____

If requesting a copy of your own records, how would you like to receive them? ☐ Paper ☐ CD or other electronic method

PURPOSE OF DISCLOSURE

☐ Client Request ☐ Coordination of Care ☐ Coordinate/Transfer

SPECIFIC AUTHORIZATIONS

Initial the below statements:

____ **DRUG & ALCOHOL:** I understand that my records may contain information, including diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for such records to be released (CFR 42, Part 2).

____ **STD/AIDS/HIV:** I understand that my records contain information regarding testing, diagnosis, or treatment of STD/AIDS/HIV. I give my specific authorization for these records to be released (RCW 70.02.220).

HIPAA

I understand that my records are protected under the Federal and/or State Confidentiality Regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Federal confidentiality rules 42 CFR, Part 2 and 45 CFR, Parts 160 and 164, and

Turn page to complete form ⟹

cannot be disclosed without written authorization unless otherwise provided for in the regulations. I further acknowledge that the information to be released was fully explained to me and permission is given of my own free will. I understand that generally the program may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. I understand that re-disclosure of this information is prohibited by law.

Information is requested in keeping with RCW 70.02.030 and HIPAA (Public Law No. 104-191). You may revoke this authorization in writing or verbally at any time prior to its expiration date; unless the agency has already disclosed the information (see Notice of Privacy Practices). Treatment, payment, enrollment or eligibility for benefits is not conditioned on your signing this authorization. This authorization expires 30 days after the end of treatment with Navos OR, if earlier, on the date it is revoked, on the date it expires under applicable state law, or on _____ date. *If the disclosure is to a financial institution or employer, the authorization expires one year after signing unless renewed by the patient.*

AUTHORIZATION TO RELEASE

I, as the client or parent or guardian of the client, give my specific authorization for this information to be released.

_____ _____

Signature of Client/Legal Representative **Date**

_____

Legal Representative's Authority to Act for Client

☐ No signature required; this information is being requested under HIPAA and Washington State Law (RCW 70.02.050, 70.02.230)