Salish Behavioral Health Administrative Services Organization
614 Division Street, MS-23 Port Orchard, WA 98366
P: 800.525.5637 | P: 360.337.7050

AUTHORIZATION, CONSENT, AND RELEASE FOR USE AND DISCLOSURE OF CONFIDENTIAL RECORDS AND INFORMATION

Individual Receiving Services ("Individual"):
Full Name (First/Middle/Last): ____
Date of Birth (MMDDYYYY): _______________

What: The health information about the Individual ("Health Information") to be used and disclosed under this Release is general health information, follow-up discussions, and (**initial all lines and check all boxes that apply**):

_____Substance Use Disorder Treatment and Diagnosis Information

_____Mental Health Information

_____AIDS/HIV/Sexually Transmitted Disease Information

AND

- ❑ All Health Information Maintained
- ❑ Medication List or Profile
- ❑ Allergies List
- ❑ Crisis Plan/Safety Plan
- ❑ Treatment Plan
- ❑ Intake / Admission / Assessment Summaries
- ❑ Discharge Summaries
- ❑ Clinical Notes
- ❑ Diagnoses
- ❑ Separate Psychotherapy Notes
- ❑ Only Health Information for these dates - From: _________________ To: _________________
- ❑ Only Health Information about a specific condition (specify):
- ❑ Other (specify): ____

From: I authorize the entity described below ("Disclosing Entity") (check all that apply):

- ❑ Salish Behavioral Health Administrative Services Organization (Salish BH-ASO)
- ❑ The Individual's Apple Health (Medicaid) Managed Care Plan
  Name of Entity (Optional): ____
- ❑ The Individual's Medicare Managed Care Plan
  Name of Entity (Optional): ____
- ❑ The Individual's Health Care Provider
  Name of Entity (Optional): ____
- ❑ Other Disclosing Entity (Name or Designation):____

To: To use and disclose Health Information to the following recipient ("Recipient") (Check all that apply):

- ❑ Salish BH-ASO (See above contact information)
- ❑ The Individual's Apple Health Plan (Name): ____
- ❑ The Individual's Medicare Managed Care Plan (Name): _______________________________
- ❑ The Individual's Health Care Provider or other Health Plan (Name): ______________________
  Address:____

City, State, Zip:____
Telephone Number: ____

❑ A Designated Person (Name):____
Address: ____
City, State, Zip: ____
Telephone Number: ____

Why: For the purpose of (check all that apply):

❑ As I requested
❑ For payment or coverage purposes
❑ For health care operations
❑ For care coordination/continuity of care
❑ To appeal a determination or to address a grievance
❑ For treatment purposes
❑ Other (specify purpose(s)): ____

I understand:

Redisclosure: If Recipient is not a health care provider or health plan, then the Health Information used and disclosed under this Release potentially may be shared or redisclosed by Recipient and may not be protected by federal or state privacy laws. When disclosing Health Information, Salish BH-ASO, if applicable, will send the attached notice with the Health Information. This notice informs Recipient that it is not allowed to disclose, without consent or authorization by or on behalf of the Individual, certain Health Information, such as certain information concerning substance use disorder, AIDS, or sexually transmitted disease.

Refusal to Sign: I may refuse to sign this Release. My refusal will not affect the Individual's ability to receive treatment, payment for services, enrollment in a health plan, or eligibility for benefits. Health Information may be used and disclosed as permitted or required by law, even if I do not sign this Release.

Revocation: I have the right to revoke or take back this Release at any time, except to the extent that the Disclosing Entity already has taken action in reliance on this Release. I may take back or revoke this Release by contacting the Salish BH-ASO Privacy Officer. Generally, my revocation must be in writing, but a verbal revocation may be permitted for Health Information that involves certain substance use disorder information.

Expiration: Unless earlier revoked, this Release will expire or end on (date or event): ______________

Authorization: I have read this Release and had an opportunity to have my questions answered. I willingly agree to this Release as, or on behalf of, the Individual:

Signature: ____ **Date:** ________________

* * *

If signed by an authorized representative on behalf of the Individual, please complete the following and attach any legal documentation:

Authorized/Legal Representative (Full Name):

Authority to Act on behalf of the Individual (specify):

- ❑ Parent
- ❑ Legal Guardian
- ❑ Holder of a Health Care Power of Attorney
- ❑ Other (describe):

NOTICE TO RECIPIENT:

To the extent applicable:

42 CFR Part 2 prohibits unauthorized disclosure of these records

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This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of any sexually transmitted disease information without the specific written authorization of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of sexually transmitted disease information is NOT sufficient for this purpose.

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