SALISH BEHAVIORAL HEALTH ORGANIZATION
Providing Public Behavioral Health Services in Clallam, Jefferson, and Kitsap Counties

Authorization for the Disclosure of Confidential Records and Information

Salish Behavioral Health Organization
Department of Human Services
614 Division Street, MS-23: Port Orchard, WA 98366-4676

Name:_____ **Birth date:**_____ **SSN:** _____

This Authorization for the Disclosure of Confidential Records and Information shall enable Salish Behavioral Health Organization to _____Request from _____Disclose to, or _____mutually exchange my personal health information with the following:

Name of person: _____

Name of entity (if applicable):_____

Address:_____

_____

Phone Number:_____ **Fax Number:**_____

The purpose of this Authorization of Disclosure is:

_____

_____

I understand this disclosure will include behavioral health/psychiatric information. Initial the type of information to be disclosed (include dates when appropriate—limit request to the least information necessary for your purpose). Specific Data authorized for disclosure:

	initials	
Drug/alcohol information (specify)	_____	_____
HIV/AIDS/STD information	_____	_____
Intake, treatment plan & level of service	_____	_____
Evaluations, tests & summaries	_____	_____
Med notes, medication & labs	_____	_____
Other information, verbal or written, which may be deemed essential to facilitate effective treatment.	_____	_____

Specific Information, if any and as noted below shall be exempt from this Authorization:

_____

_____

I authorize (initial one): _____ALL Episodes of Care or_____ dates of services from _____through_____

This Authorization for Disclosure shall expire on the following date: _____
(Authorizations for release to a financial institution or employer are limited to 90 days from the date signed)

THIS INFORMATION WILL BE HANDLED BY ALL PARTIES IN A CONFIDENTIAL MANNER AND WILL NOT BE RELEASED FURTHER WITHOUT SPECIFIC AUTHORIZATION AS ESTABLISHED IN, AND IN ACCORDANCE WITH CFR 45.164, RCW 70.02, AND RCW 71.24, 71.05, and 71.34. I understand that my endorsement, or lack thereof, of this Authorization for Disclosure is not a condition for treatment, payment, enrollment, or eligibility. I understand that this authorization may be revoked by me, in writing, at any time.

I understand I have the right to revoke this authorization at any time. The revocation must be in writing and presented to SBHO staff. I also understand that the revocation will not apply to circumstances where state or federal regulation require access to information for specific incidents including, but not limited to, reporting incidents of abuse, neglect, or domestic violence, for qualified research, audit or program evaluation, reporting to a public health authority to prevent or control disease, emergency medical care, court order, or to facilitate an application or claim for public benefits.

CONSENT OF A MINOR: All disclosures of minor's shall be in accordance with RCW 71.34. A minor (13-17) client's signature is REQUIRED in order to release information concerning care for behavioral health conditions. A minor (14-17) client's signature is required in order to release information concerning care for conditions relating to the minor's sexuality including but not limited to AIDS/HIV, contraception, pregnancy and/or termination, sterilization and sexually transmitted diseases.

I hereby give Authorization for this Disclosure of Information under the conditions noted above:

Individual/Personal Representative:_____ **Date:**_____
(If individual is under the age of 13, or a guardian (specify type and provide a copy of the court appointment) is involved, sign below)

Parent/Guardian Signature:_____**Relationship:**_____

Witness Signature:_____**Relationship:**_____

Revocation of Authorization for Disclosure

I hereby revoke this Authorization for Disclosure of Confidential Information. All components of this Authorization are invalid as of this date. I attest that this revocation was not "pre-authorized", requested, influenced or coerced by staff in any manner.

Individual/Guardian/Personal Representative: _____ Date: _____
(If individual is under the age of 13, or a guardian (specify type) is involved, sign below)

Parent/ Guardian Signature: _____Relationship:_____

SBHO Staff Signature:_____ Staff Name:_____

*If the revocation was made by the individual by phone or by any other means than a written request, check here:____