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| CompassHealthBW | *RELEASE OF INFORMATION* |

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| ***Client Name/ID/DOB*** *(or affix label)* | Previous/Maiden Name or Alias: |

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| COMPASS HEALTH Address:    Phone:  Fax:  Attn: |  | **Compass Health may**  **Disclose**  **Receive**  **Exchange**  **the protected health information indicated below with:**  Person or Facility:  Address:    Phone:  Fax: |

I authorize the release of **any and all of the following medical, mental health and/or substance use disorder information, as specified,** which may be contained in my records (Check all that apply)with the following date parameters:

All Dates - or - Date Range:

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| Behavioral Health Diagnoses  Mental Health Assessment  Psychiatric Evaluations  Substance Use Disorder Assessments  Treatment/Crisis Plans  Treatment Plan Reviews  Psychiatric Treatment Notes | Progress Notes  Listing of Services Provided  Compliance Reports  Medication Summary  Nursing Assessments  History and Physical  Medical Diagnoses | Medical History/Profile  Lab Results  Drug Screen Results  Substance Use Abstinence Status  Attendance Records  Discharge Summary  Other (specify): |

**Purpose of this Disclosure:** (check all that apply)

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| Assisting in diagnosis and treatment  Assuring continuity of care  Treatment planning  Coordinating care/service delivery  Report on progress  Referral for other treatment  Inform others of treatment status | Verify compliance  Legal Consulting  Determine disability  Vocational  At the request of the individual  Educating natural supports about behavioral health issues  Other (specify): |

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| I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105) | Approve  Deny |

As the individual signing, I understand the terms of this Authorization, including:

1. I am giving my permission to Compass Health to disclose my confidential health records.
2. That my signing of this Authorization is voluntary.
3. My health information is protected by federal HIPAA Privacy regulations.
4. If the organization authorized to receive the Information is not a health plan, healthcare clearing house or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
5. Staff of Compass Health may not condition treatment, payment, or enrollment on the signing of this Authorization.
6. A photocopy of this Authorization is as valid as the original, and that I am entitled to a copy of this Authorization. Compass Health reserves the right to utilize any and all secure methods for releasing the information specified above.
7. Paper or electronic copies of my records may be used to facilitate disclosure of my information.
8. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing.
9. I understand that I have the right to refuse to sign this Authorization.
10. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.

This Authorization is effective (date):

**Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from services at Compass Health, whichever is *later*.**

NOTICE: Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

Signature of client, or client’s parent/guardian/legal representative Date

(*Office Use Only*) Document was provided to the client in an alternative language