Authorization to Release Behavioral Health/SUD Information

I, ____, authorize

Name of Patient/DOB

Blue Mountain Counseling of Columbia County; 221 E. Washington Street, Dayton, WA 99328 to disclose and receive information from: **Behavioral Health**: ☐ **SUD**: ☐

____

(Name of person or organization to which disclosure is to be made)

The following information: **initial** appropriate areas

- ☐ Any and all records including, but not limited to medical, psychiatric and substance abuse history, diagnosis, progress in and / or response to treatment and prognosis
- ☐ Psychological evaluation including testing and results/Psychiatric Evaluation/Medications
- ☐ HIV/AIDS test results, diagnosis, or treatment/Sexually transmitted diseases
- ☐ Other (specify):____/________________________

Consumer initials

The purpose of the disclosure authorized in this is to: (Be as specific as possible)

____

____

I understand that my records are protected under the Federal regulations governing confidentiality, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

____

(Specification of the date, event or condition which this consent expires)

I understand that generally Blue Mountain Counseling of Columbia County may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

____

Signature of Patient Date

Signature of parent/guardian/authorized representative: ____

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information Prohibition on Redisclosure of Confidential Information This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Reviewed on : ____________________ Client initials: __________________

Reviewed on : ____________________ Client initials: __________________

Valid for 1 year, unless revoked by client

Entered into clinic tracker Y/N