**Spokane County Counseling and Recovery Services (CAReS)**

312 W. 8th Avenue, Spokane, WA 99204

Telephone: 509-477-4388 / Secure Fax: 509-477-3615

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the Spokane County Community Services, Housing, and Community Development CAReS Division to exchange information with the following individual or entity:

Name and relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By initialing items below, I authorize the release and exchange of the following types of information:

MH Treatment Discharge Summary  SUD Diagnostic Assessment

MH Treatment Notes  SUD Treatment Notes

Involuntary Treatment History/Records (RCW 71.05)  SUD Treatment Discharge Summary

MH Diagnostic Assessment  SUD Treatment Continuing Care Plan

MH Treatment Plan  SUD Treatment Plan

Psychological Evaluation  Treatment Compliance Reports (Requested by DOC)

Psychiatric Evaluation  Involuntary SUD Treatment History/Records (RCW71.05)

Forensic Discharge Review (State hospital)  Health and Physical

Verbal exchange of information  Emergency Contact

Presence and attendance  UA/Lab results

Information regarding treatment progress

(3) Other: Specify other information as necessary for cross-system collaboration:

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**The purpose of the above disclosure is to secure suitable and affordable housing.**

**The purpose of the above disclosure is to coordinate medically-necessary behavioral health treatment services.**

1. I understand my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164 and RCW 70.02. Federal rules prohibit the agencies listed above from making any further disclosure of this information unless further disclosure is expressly permitted by my written consent 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. I understand a separate written consent is required to release information relating to testing, diagnosis and/or treatment for HIV/AIDS or any other sexually transmitted disease.
2. I also understand that this authorization shall remain in effect through the date listed below. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further understand that I must provide any notice of revocation in writing to CAReS Integrated Healthcare Manager at 312 W. 8th Avenue, Spokane, WA 99204.
3. Health information includes information collected from me, as the client, or created by a Provider, or information received by a Provider from another health care provider, a health plan, my employer, a healthcare clearinghouse or other community sources. Health information may relate to my past, present, or future physical or mental health or condition, the provision of health care, or payment for health care services. I understand that my health records are protected under State, WAC 388-865 and RCW 71.05 and cannot be disclosed without written consent unless otherwise provided for in the regulations. This authorization addresses and permits the releases of any and all medical information protected by the Drug Abuse Office and Treatment Act of 1972 (P.L. 92.255) and the Comprehensive Alcohol Abuse and Alcoholism Regulations (42 CFR), which covers Drug and/or Alcohol Information Release. I understand that this written authorization is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, and/or drug and alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.
4. I understand that the Provider cannot guarantee that the Recipient of my information will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Client in federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by my written consent or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
5. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Spokane County CAReS Program.
6. I understand that such health care information may be exchanged verbally, in person, by phone, fax, or mail.

I have read and understand the terms of this Authorization

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| --- | --- | --- |
| **Individual’s Printed Name:** | | **Individual’s Signature:** |
| **Today’s Date:** | **Date of Birth:** | **Last 4 of Social Security Number:** |
| **Printed Name of Parent/Guardian/Health Care Agent (proxy)/other representative if the individual is not competent to give consent:** | | **Signature of Parent/Guardian/Health Care Agent (proxy)/other representative if the individual is not competent to give consent:** |
| **Relationship to the Individual:** | | **Today’s Date:** |
| **Name(s) used in Treatment:** | | |
| **Authorization Expires on: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_**  **(Authorization expiration date shall not exceed one (1) year from the individual’s enrollment in Spokane County Counseling and Recovery Services (CAReS)** | | |

The Individual or Guardian was offered and accepted a copy of this Authorization.

The Individual or Guardian was offered and declined a copy of this Authorization.