Community Services Department | Justin Johnson, Director

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Spokane County Regional Behavioral Health Administrative Services Organization (SCRBH-ASO)
Spokane County Community Services Department
Mailing Address: 1116 W. Broadway Avenue Spokane, WA 99260
Office: 509-477-4722 / Fax: 509-477-6204

CCID: ____________ NAME: ____ DOB: _________ SEX: ____
Last First MI

AKA: ____

I request and authorize the below named agencies to receive or release health care information for the continuity of care.

☐ **Spokane County Community Services Department** Diversion Case Manager & Peer Support Specialist 1100 W. Malon Ave, Spokane, WA 99260 Office: 509-477-4556 / Fax: 509-477-6204	☐ **Spokane County Detention Services** Detention Services Mental Health Department 1100 W. Mallon Ave, Spokane, WA 99260 Office: 509-477-6686 / Fax 509-477-6683
☐ **Spokane County Prosecuting Attorney's Office** 1100 W. Mallon Ave, Spokane, WA 99260 Office: 509-477-3662 / Fax: 509-477-3409	☐ **Spokane County Public Defender's Office** 1033 W. Gardner Ave, Spokane, WA 99260 Office: 509-477-4246 / Fax: 509-477-2567
☐ **Office of the City Prosecuting Attorney's Office** 909 W. Mallon Ave, Spokane, WA 99201 Office: 509-835-5988 / Fax: 509-835-5927	☐ **City Public Defender's Office** 824 N. Monroe Street, Spokane, WA 99201 Office: 509-835-5955 / Fax: 509-835-5987

______________________________ ______________________________________ ____________________
Behavioral Health Treatment Provider Address Phone/Fax number

This request and authorization applies to:

☐ Medication ☐ Treatment including treatment dates, Health conditions
☐ Health Care History ☐ Tuberculosis testing lab results, x-rays
☐ Psych Eval ☐ X-Rays/CT scans/ MRI/ Specialist Reports
☐ 5177 Diversion Program ☐ Other: ________________________________

Purpose for which disclosure is being made (please check all that apply):

☐ 5177 Diversion Program Services ☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal ☐ Medical Records

SPECIFIC CONSENT

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health and drug/alcohol abuse. I am specifically authorizing release of all health care information related to such testing, diagnosis and/or treatment of aforementioned conditions in accordance with 42 CFR, Part 2, RCW 71.34.200, RCW 70.24.105. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise allowed or required by law. I also understand 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.

Specified date, event, or condition upon which consent expires: ____

RIGHTS OF THE PATIENT:

This authorization is voluntary; I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may further disclose it in accordance with HIPAA, 45 CFR Parts 160 & 164 and 42 CFR Part 2.

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 C.F.R. 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 C.F.R. 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.

SIGNED: ____ **DATE:** ____________________