3857 Martin Way E – Olympia, WA 98506-5218	**Consent for Release of Confidential Information: Mental Health and/or Substance Use Disorder Treatment Services**

Client Name:____**Date of Birth:**____________________________

I hereby authorize ____ or other agency designated staff of BHR to:

☐ Exchange information with ☐ Disclose to ☐ Receive from

____

(Name and Address of Individual/Agency/Facility)

Please have the client initial each section relevant to this consent

Mental Health / Psychiatric Treatment Records		**Substance Use Disorder Treatment Records**	
______	Inpatient Admit/Discharge Information	______	Assessment/ASAM
______	Medical Records/Medications	______	Discharge Summary
______	Intake/Treatment Summaries	______	Treatment Plans
______	Progress Notes/Reports	______	Progress Notes/Reports
______	Laboratory, X-Ray, EKG Reports	______	UA Results / TB Test Results
______	Psychiatric Evaluation Records	______	Treatment Compliance/Participation Reports
______	Substance use/Diagnosis/Treatment	______	5-Year Driving Abstract
______	Treatment Compliance/Participation Reports	______	Probation/Parole Reports
______	Probation/Parole Reports	______	Emergency Contact Only
______	Other (specify)	______	Other (specify)

______AIDS/HIV/STD	I understand that my records may contain information regarding testing, diagnosis or treatment of HIV/AIDS or sexually transmitted diseases. I give my specific authorization for these records to be released (Per RCW 70.24.105)

Disclosure of information authorized herein in required for the following purpose(s):

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Unless canceled earlier by me, this authorization will expire at the end of this treatment episode, remaining in effect until I am discharged from BHR, or 90 days after date of signature, whichever occurs last.

I understand that my Substance Use Disorder treatment records are protected under the Federal regulations governing confidentiality (42 CFR Part 2 and HIPAA 45 CFR Parts 160 and 164). This information shall be kept confidential and further disclosure to any other person/organization is prohibited without my specific written consent, or as otherwise specified by law.

I understand that I may revoke this authority at any time, except to the extent that action has already been taken. To revoke this authorization, the request must be in writing to the BHR Medical Records Department. BHR is prohibited from conditioning treatment, payments, enrollment, or eligibility for benefits on my agreement to sign this authorization. I understand that the information used or disclosed as described by this authorization may no longer be protected by federal law and could be used or re-disclosed by the receiving party. A copy or fax shall be considered valid in lieu of the original.

____ ______________________________

Client Signature Date of Signature

____ ______________________________

Parent/Guardian/Legal Representative Signature Date of Signature

☐ Copy offered to client ☐ Client declined a copy