AUTHORIZATION FOR DISCLOSURE AND USE OF SUBSTANCE USE DISORDER PROTECTED HEALTH INFORMATION

Name: ____________________DOB: ____________ Previous Name: ________________

By signing below, I authorize:

____

(name of substance use disorder treatment provider)

To disclose to the following organizations and for the following organizations to redisclose and share with each other:

The King County Behavioral Health and Recovery Division (KCBHRD), the Washington State Health Care Authority, and one of the following Managed Care Organization (s) as applicable, Amerigroup, Community Health Plan, Coordinated Care, United Healthcare, or Molina,

The following information related to my substance use disorder treatment:

- This signed consent form
- Identifying information
- Financial information
- Admission date(s)
- Service encounters
- Diagnosis(es)
- Clinical information
- Program specific substance use disorder assessment
- Anticipated discharge date
- Discharge Information (if applicable)

Purpose of the disclosure: To support treatment, coordination of care, payment and health care operations.

By signing this form, I understand:

- When I am asked to fill out this consent, I am entitled to a copy.
- I have the right to revoke this consent at any time. Any revocation will not affect any action that has already been taken based on the original authorization.
- Without my express revocation, this consent will expire upon the completion of treatment and exit from the KCBHRD; unless I am under the supervision of the Washington State Department of Corrections at the time of exit from the KCBHRD, then this authorization will expire at the end of the term of supervision.
- My substance use disorder records are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR Part 2.
- I will be denied substance use disorder services funded by KCBHRD if I refuse to sign this form.

Signature *(Client or Person Authorized to Give Authorization)*	***Date***

If Signed by person Other Than the Client, Print Name, Provide Reason, relationship to the Client, Description of Their Authority

All disclosures and redisclosures must be accompanied by the following notice: "This information has been disclosed to you from records protected by federal confidentiality rules (42 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."