



**CONSENT for RELEASE of SUBSTANCE USE DISORDER TREATMENT  
INFORMATION for SERVICE COORDINATION**  
**King County Behavioral Health and Recovery Division**  
 The Chinook Building, 401 Fifth Ave, Suite 400, Seattle, WA 98104  
 Fax: 206-205-1634

I, \_\_\_\_\_ authorize the King County Behavioral Health and Recovery Division (BHRD), to 1) disclose substance use treatment information to Public Health Seattle and King County, mental health treatment agencies, substance use treatment agencies, and healthcare agencies, as needed, if they are involved in my past, present or future care, and 2) disclose substance use treatment information to One Health Port and Collective Medical who may disclose this information to mental health treatment agencies, substance use treatment agencies, and healthcare agencies, as needed, if they are involved in my past, present or future care.

The following information related to my substance use disorder treatment will be shared as needed: name and other identifying information (such as DOB, gender, race), ProviderOne ID, disabilities, diagnosis, case manager name and contact information, where and when I was enrolled and the types of substance use disorder and/or mental health treatment services received within the King County Provider Network.

The purpose of this disclosure is to support service coordination, continuity of care and healthcare operations for my treatment.

**By signing this form, I understand:**

- When I am asked to fill out this consent, I am entitled to a copy.
- I have a right to request and receive a list of agencies that have received my substance use treatment information.
- I have the right to revoke this consent at any time. Any revocation will not affect any actions that have already been taken based on the original authorization.
- Without my express revocation, this consent will expire upon the completion of treatment and exit from King County Provider Network.
- 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 Code of Federal Regulations (CFR) Part 2.
- I do not have to sign this form to receive substance use disorder services from the King County Provider Network.

<b>Signature</b> (Client or Person Authorized to Give Authorization)	<b>Date</b>
<i>If Signed by Person Other Than the Client, Print Name, Provide Reason, relationship to the Client, Description of Their Authority</i>	

**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.”

***For Program Use Only:*** *The client chooses not to sign this form.*

*Staff signature* \_\_\_\_\_ *Date* \_\_\_\_\_