V6

**AUTHORIZATION TO DISCLOSE AND REDISCLOSE**

**SUBSTANCE USE DISORDER PROTECTED HEALTH INFORMATION**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Previous Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I authorize the following**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Name of Provider Organization)*

**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, and**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Adult SUD Residential Treatment Facilities\*** | | | | |
| American Behavioral Health Systems Inc. | | Co-Occurring Residential Program (CORP) | Specialty Services II | | |
| Olalla Recovery Centers | | Pioneer Center North | Sea Mar Tacoma | | |
| Sea Mar Turning Point (Seattle) | | Key Recovery and Life Skills |
| North Sound Behavioral Health | | Triumph Treatment Services | Valley Cities- Recovery Place (Seattle) | | |
| **Youth SUD Residential Treatment Facilities\*** | | | | |
| Daybreak Brush Prairie | Excelsior Youth Centers, Inc. | | |  |
| Sea Mar Renacer (Seattle) | Sea Mar Visions | | |  |

*\*Information about these facilities is available from your provider.*

**To communicate with, disclose and redisclose to one another the following information:**

* This signed consent form
* Identifying information
* Financial information
* Clinical Assessment
* Care Coordination Information
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of the disclosure**: For KCBHRD to coordinate my referral to substance use disorder residential treatment.

**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 KCBHRD.
* 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 agree to the redisclosure of my information to the listed SUD residential treatment providers.
* If I do not sign this form, KCBHRD will not be able to coordinate referrals for me to the SUD residential treatment programs.

|  |  |
| --- | --- |
| ***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.”