Washington Authorization For Release of Health Protected Information

AUTHORIZATION TO DISCLOSE RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records:	FORMER NAMES

CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

DISCLOSE TO:

NAME LAST	FIRST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS NAME IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

REASON FOR DISCLOSURE (NOT REQUIRED)

AUTHORIZATION:

SOURCES: I authorize the following organizations to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.

☐ The following programs only (check all that apply):

- ☐ Behavioral Health Administration (BHA)
- ☐ Child Support (DCS)
- ☐ Developmental Disabilities (DDA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Special Commitment Center (SCC)
- ☐ Community Services (CSD – public assistance)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC)
- ☐ Human Resources and Payroll
- ☐ Other: _____

☐ All Departments

RECORDS: I authorize the following records to be disclosed:

- ☐ Client records held by parts of organizations marked above
- ☐ Other confidential records held by parts marked above
- ☐ Personal information in employment-related records
- ☐ All my client records
- ☐ Records on the attached list
- ☐ The following records only:

I want to limit the records to be disclosed as follows (by date, type of record, etc.):

☐ I am not asking that records be disclosed at this time. Please place this authorization in my client file.

PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

SPECIAL RECORDS: I give my permission to disclose the following information held in records (check all that apply):

- ☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220)
- ☐ Mental health records (RCW 70.02.230 or 240)
- ☐ Substance Use Disorder records (42 CFR Part 2)

- This permission is valid for 180 days or ☐ until _____ (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply to organization after this they are produced.
- A copy of this form is valid to give my permission to disclose records. The organization may charge to provide copies of its records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (AREA CODE)

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.