

Skamania County Community Health

710 SW Rock Creek Drive PO Box 1492 Stevenson, WA 98648 Ph: (509) 427-3850 Fax: (509) 427-0188

CONSUMER AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Consumer Name:		Date of Birth:	
I hereby authorize Skamania Cou	nty Community Health to:		
☐ Release Information to:	☐ Exchange Information with:	Obtain Information from:	
Person/Provider:			
Street Address, City, State, Zip:			
Phone Number:	Fax Number:		
Please initial all records/informa	tion you would like released to or reques	ted from (including verbally) outside source	
Mental Health treatment: AssessmentProgress NotesTreatment PlansCrisis PlansPsychological TestingProbation/Parole ReportsMedication IntakeMedication RecordsAcademic Testing/ClassroomOther	Assessment Progress Notes Treatment Plans Crisis Plans Probation/Parole Reports Other	Medical Services: Lab ResultsImmunizationsChart NotesMedication RecordsX-Ray/EKG ReportsHospital treatment/DischargeOther	
	CONTINUITY OF CARE unless otherwise onal Records Consumer's Report	se specified below:	
alcohol abuse (per 42 CFR Part 2) diseases (per RCW 70.24.105). I	, the testing, diagnosis or treatment of H	ealth diagnosis and treatment, drug and/or IV/AIDS and/or sexually transmitted protected records to be released. (If you do	
I DO NOT want the following inf	formation to be released: (If nothing is sp	ecified, all information will be included)	

TERMS

This authorization will remain in effect for one calendar year following the date of signature.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as stated above. The revocation may be verbal if I am a client in the Alcohol and Drug Treatment Program and must be in writing if I am enrolled in a Mental Health Services Program.

I understand that all of my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, though there is no guarantee that this individual/agency will not re-disclose my health information to a third party. The third party may not be required to abide by applicable federal and state law governing the use and disclosure of my health information; thus, my health information may no longer be protected by HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

I understand that any information regarding participation in an Alcohol and Drug treatment program is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. 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 prosecute any alcohol or drug abuse patient.

Information relating to HIV/AIDS is specifically prohibited by law to be re-disclosed.

A copy or FAX shall be considered valid in lieu of the original.

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly, and voluntarily, authorize Skamania County Community Health to use or disclose health information in the manner described above.

Signature of Authorizing Individua	al Date	Signature o	f Witness
Print Name		Witness Printed Name	
A copy of signed Authorization has been	en offered to the individual:	Accepted	■ Denied
***********	*********	******	********
If 13 years or younger or otherwise un	able to sign this Authorization	, please complete	the information below:
	/		
Signature	Date	Witnes	S
Relationship to Client:	Parent		
***********	*********	******	*********
The following individuals must provide d	ocumentation proving authoriz	zed representation	ı:
☐ Guardian ☐ Health care Power of Attorney	Authorized health care repr Other Authorized Personal		or Mental Health