ASSOCIATED BEHAVIORAL HEALTH
how health care works

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ DOB : _____
authorize **Associated Behavioral Health Care** to disclose / exchange specified confidential medical, psychiatric (including alcohol and/or drug), HIV / AIDS test results or diagnosis, and / or educational information during the course of my treatment to and from:

_____
(Name and address of person / organization to whom disclosure is made)

Phone:_____ Fax:_____

For the purpose of an exchange of information by: **PHONE** **FAX** **LETTER** **EMAIL**

Consent applies to all of the following:

- Dates of Attendance at ABHC &/or other treatment programs (CD, DV, or MH)
- Reports on Patient's progress towards treatment objectives & attendance
- Program Discharge Summary from CD, DV, or MH
- Psychological Test Reports
- Medical Records
- Medical or Laboratory Reports
- Chemical Dependency and/or Domestic Violence Records
- Other:_____

or choose the following:

[ ] LIMITED to the following:_____or check either of the following

[ ] Acknowledgement of Patient's presence in facility ONLY [ ] Financial Information

For Custody Eval only:

[ ] Custody Evaluation Collateral Consent for the following information to be released:

- Perception of above named client's substance use;
- Collateral interview as required by Washington State to fully evaluate the client

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR, Part 2 or Health insurance Portability and Accountability Act (HIPAA) and State (RCW 71.05.390 - WAC 275-56-240). Clinicians may discuss care about mutual patients without written consent unless specifically prohibited by me. Additionally, my alcohol and/or drug treatment records are also protected under the federal regulations 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This release for court related services will expire ninety (90) days after completion of court proceedings or after discharge from treatment whichever is latest. This release will remain in place unless written notification of termination is received.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that ABHC will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent if minor Date

To receiving organization, fax records to confidential fax at: 425-671-6198

Bellevue Branch	North Seattle Branch	West Seattle Branch	Kent Branch
425-646-7279	206-781-2661	206-935-1282	253- 867-5344