Columbia River Mental Health Services

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____ ID#: _____

I authorize with my INITIALS that Columbia River Mental Health Services and the below named person/entity can release the following information to each other regarding: (*INITIAL ALL THAT APPLY*)

_____ Mental Health/Psychiatric **_____ Substance Use Disorder** **_____ HIV/STD Information**

Person/Entity

Name: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Information to Be Released: (*INITIAL ALL THAT APPLY*)

_____ All Treatment Records	**_____ Presence in Treatment**	**_____ Scheduling and Appointments**
_____ Intake/Assessment(s) and Summary Reviews	**_____ Treatment Plans**	**_____ Progress/Medical Notes**
_____ Treatment Recommendations and Compliance	**_____ Housing Services Records**	**_____ Billing/Financial/Insurance**
_____ All Medical; Prescriptions, medication summary and use, lab results, UAs, breathalyzers, and other medical records	**_____ Third-Party Payers; all treatment records needed for billing and review purposes**	**_____ Emergency Contact Information**
_____ Other:		

Purpose(s) of Disclosure	☐ **To obtain a copy of my records**	☐ **To resolve legal and/or custody issues**	☐ **Continuity of Care**
	☐ **To obtain/maintain benefits or services**	☐ **To acquire third-party reimbursement of services**	☐ **Emergency Contact**
	☐ **Other**		

I, the undersigned, understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that some of the confidential information I have authorized to be disclosed will be generated and disclosed over the course of my future treatment and after the date I signed this authorization. By signing this authorization, I authorize future disclosures made in reliance on this consent and understand that it may include disclosures after my discharge from treatment. I understand that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon; and **unless earlier revoked shall expire 90 days after discharge.** I understand that, except when I am receiving research-related treatment or health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Columbia River Mental Health Services. I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. Parent/guardian signature required for minors under age of consent. An authorized representative must sign releases for incompetent and deceased patients. A witness signature is required to verify the identity of signer.

X _____ _____

Signature authorizing this consent for Release ☐Client ☐ Parent/Guardian/Authorized Representative Date

X _____ _____

Witness Signature Date

This notice may accompany a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Parts 2, 160 and 164). 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 C.F.R. Parts 2, 160 and 164. 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.