**AUTHORIZATION FOR USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PROTECTED HEALTH INFORMATION**

**King County Behavioral Health and Recovery Division**

The Chinook Building, 401 Fifth Ave, Suite 400, Seattle, WA 98104

Fax: 206-205-1634

[](http://kcweb.metrokc.gov/logo/newLogo/emf.zip)

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

**By signing below, I authorize**:

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| *(name of substance use disorder treatment provider)* |

**To disclose to King County Behavioral Health and Recovery Division (BHRD) the following information:**

* This signed consent form
* Identifying information
* Financial information
* Admission date(s)
* Service encounters
* Diagnosis(es)
* Clinical information
* Program specific substance use disorder (SUD) assessment
* Anticipated discharge date
* Discharge Information (if applicable)

**Purpose of the disclosure**: To support treatment, coordination of care, payment and health care operations.

**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 BHRD.
* 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 Code of Federal Regulations (CFR) Part 2.
* I will be denied SUD services funded by King County BHRD if I refuse to sign this form.

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| ***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.”