Sound Mental Health **MRN:**

AUTHORIZATION to REQUEST, SHARE OR RELEASE HEALTHCARE INFORMATION

Client Name: (F,M,L)	**AKA:**
Date of Birth:	**SSN:**
Address:	
City/State/Zip Code:	**Phone Number(s):**

*Information to be shared or **released by:***	*Information to be shared or **released to:***
Name:	Name:
Organization:	Organization:
☐ SMH – Indicate contact/address information in next section.	☐ SMH – Indicate contact/address information in next section.
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

☐ **505 29th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651**	☐ **4240 Auburn Way North Auburn, WA 98002 253-876-8900 Fax: 253-876-8980**	☐ **4238 Auburn Way North Auburn, WA 98002 253-876-7600 Fax: 253-876-8980**	☐ **14216 NE 21st Street Bellevue, WA 98007 425-653-4900 Fax: 425-653-4939**	☐ **6100 Southcenter Blvd., Suite 200 Tukwila, WA 98188 206-444-7800 Fax: 206-444-7890**
☐ **14270 NE 21st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790**	☐ **16225 NE 87th St.,Suite A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790**	☐ **11629 Avondale Road Redmond, WA 98052 425-653-5070 Fax: 206-726-5790**	☐ **8705 166th Ave NE Redmond, WA 98052 425-869-6634 Fax: 206-726-5790**	
☐ **1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210**	☐ **122 16th Ave E Seattle, WA 98112 206-302-2700**	☐ **9706 4th Ave NE, Suite 303 Seattle, WA 98115 206-302-2900 Fax: 206-302-2750**	☐ **2719 East Madison, Suite 200 Seattle, WA 98112 206-302-2600 Fax: 206-726-5769**	

☐ *This is a 90 day **authorization to request or disclose** healthcare information.*
OR
☐ *This authorization allows **mutual exchange** of information between the entities listed above in order to provide and/or coordinate care until 30 days after discharge from this episode of care, unless revoked by the client.*

The person or organization listed above is:

☐ Emergency/ Family Contact ☐ Care Provider ☐ Case Worker
☐ Care Coordinator ☐ CSO ☐ School-Based Care Contact

The purpose of the request / disclosure is:

☐ Care Coordination ☐ Referral ☐ Disability Confirmation ☐ Legal ☐ Other (specify) _____

Specific information to be disclosed:

☐ Status Report
☐ Information to Coordinate Care
☐ Initial Assessment
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Treatment Plan
☐ Recent Treatment/Progress Notes
☐ Discharge Summary
☐ Medication Information
☐ Physical Health Information
☐ School Records/ IEP
☐ CD Assessment
☐ Other: _____

If information is requested for specific dates, please note dates:

I understand that my healthcare information/record contains information about my treatment and services I receive through a variety of programs offered at SMH. This may include information about my mental health, alcohol and drug dependence, STDs and HIV / AIDS status and other specific areas (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.

I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/health insurers. HIPAA does not protect the disclosure and possible re-disclosure of personal health information to individuals or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.

This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My treatment at SMH is not conditioned on signing this authorization. This agreement to request, release or share information may be revoked by me, in writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.

Client Signature: ***Date:*** / /

If Appropriate-
Parent/Guardian Signature: ***Date:*** / /

Relationship to Client: ☐ Parent ☐ Guardian-Appointed ☐ Guardian-Healthcare Power of Attorney
☐ Guardian-Other Specify:

References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR Part 2, HIPAA

Revised: 02-20-2013

Sound Mental Health MRN:

AUTHORIZATION to REQUEST, SHARE OR RELEASE HEALTHCARE INFORMATION

Client Name: (F,M,L)	**AKA:**
Date of Birth:	**SSN:**
Address:	
City/State/Zip Code:	**Phone Number(s):**

Information to be shared or released by:	*Information to be shared or released to:*
Name:	Name:
Organization: King County Prosecutor's Office	Organization: Regional Mental Health Court
☐ SMH – Indicate contact/address information in next section.	☐ SMH – Indicate contact/address information in next section.
Address: 516 Third Avenue, W554	Address: 516 Third Avenue, E-319
City/State/Zip: Seattle, WA 98104	City/State/Zip: Seattle, WA 98104
Phone: 206-296-9000	Phone: 206-477-6283

☐ 505 20th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651	☐ 4240 Auburn Way North Auburn, WA 98002 253-876-6900 Fax: 253-876-6980	☐ 4239 Auburn Way North Auburn, WA 98002 253-876-7600 Fax: 253-876-6980	☐ 14216 NE 21st Street Bellevue, WA 98007 425-653-4900 Fax: 425-653-4939	☐ 6100 Southcenter Blvd., Suite 200 Tukwila, WA 98188 206-444-7800 Fax: 206-444-7890
☐ 14270 NE 21st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790	☐ 16225 NE 87th St., Suite A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790	☐ 11629 Avondale Road Redmond, WA 98052 425-653-5070 Fax: 206-726-5790	☐ 9705 168th Ave NE Redmond, WA 98052 425-559-5634 Fax: 206-726-5790	
☐ 1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210	☐ 122 16th Ave E Seattle, WA 98112 206-302-2700	☐ 9705 4th Ave NE, Suite 303 Seattle, WA 98115 206-302-2900 Fax: 206-302-2750	☐ 2719 East Madison, Suite 200 Seattle, WA 98112 206-302-2600 Fax: 206-726-5769	

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The purpose of the request / disclosure is:

☑ Care Coordination ☐ Referral ☐ Disability Confirmation ☑ Legal ☐ Other (specify) _____

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Revised: 02-20-2013

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Date of Birth:	**SSN:**
Address:	
City/State/Zip Code:	**Phone Number(s):**

*Information to be shared or **released** by:*	*Information to be shared or **released** to:*
Name:	Name:
Organization: RMHC ACA Defense	Organization: Regional Mental Health Court
☐ SMH – Indicate contact/address information in next section.	☐ SMH – Indicate contact/address information in next section.
Address: 110 Prefontaine Place S, Ste 200	Address: 516 Third Ave. E-319
City/State/Zip: Seattle, WA 98104	City/State/Zip: Seattle, WA 98104
Phone: 206-624-8105	Phone: 206-477-6283

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Name:	Name:
Organization: Dept. of Public Defense	Organization: Regional Mental Health Court
☐ SMH – Indicate contact/address information in next section.	☐ SMH – Indicate contact/address information in next section.
Address: 516 Third Avenue, E-820	Address: 516 Third Avenue, E-319
City/State/Zip: Seattle, WA 98104	City/State/Zip: Seattle, WA 98104
Phone: 206-296-7662	Phone: 206-477-6283

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Client Signature: ***Date:*** / /

If Appropriate-
Parent/Guardian Signature: ***Date:*** / /

Relationship to Client: ☐ Parent ☐ Guardian-Appointed ☐ Guardian-Healthcare Power of Attorney
☐ Guardian-Other Specify:

References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR Part 2, HIPAA

Revised: 02-20-2013

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
JAIL HEALTH SERVICES

Public Health is not obligated to honor this request unless all portions are completed.

The undersigned authorizes:

☐ Outside Agency (give complete name & address) or ☐ Jail Health Records

_____ _____

_____ _____

_____ _____

To release the records of: _____ _____

Client Name Alias (Optional)

_____ _____

Client Phone # Date of Birth

Records will be released to:

_____

Person & Institution Affiliation

_____

Street Address City/State/Zip

_____ _____

Phone Number Fax Number (Optional)

Date(s) of services requested: _____

(If no date given: the last incarceration information will be released)

For the purpose of: ☐ medical/dental ☐ legal ☐ personal ☐ other (describe) _____

Please verify what you are requesting:

☐ Release Medical Health Records

☐ Other Public Health Medical Records, specify: _____

☐ Verbal Information Exchange: _____

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

When checked, this authorization Excludes release of the following information:

☐ Drug or alcohol abuse diagnosis or treatment ☐ HIV (AIDS) testing/treatment

☐ Confirmed STD test results and/or treatment ☐ Psychiatric

This authorization expires (insert date or event, invalid if left blank) _____

Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) ☐ Yes ☐ No

_____ _____

Client/Guardian Signature Date

_____

Relationship to Patient

_____ _____

Interpreter Date

Your rights under federal and state law

You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending a written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES

Public Health
Seattle & King County

Jail Health Services
500 Fifth Avenue
Seattle, WA 98104
Phone: 206-296-1091
Fax: 206-296-1771

Jail Health Services
620 W James S
Kent, WA 98032
Phone: 206-205-2410
Fax: 206-205-2439

Patient Name: _____

BA#: _____

HR#: _____

D.O.B.: _____