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.:

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723) , 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: **Department of Veterans Affairs** (Print or type name and address of Health care facility)
VA Puget Sound Health Care System
1660 S. Columbian Way
Seattle, WA 98108-1597

PATIENT NAME (Last, First, Middle Initial)\

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released included information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED: (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ Copy of Hospital Summary ☐ Copy of Outpatient Treatment Note(s) ☒ Other

Two way verbal and written information regarding all aspects of health care, including mental health and/or substance use disorder treatment records and housing status.

Purpose(s) or need for which the information is to be used:
☒ Assist client in meeting legal requirements ☒ Coordination of Care ☐ Transfer Tx to another agency
☐ Assist with housing application ☐ Other:

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on date: (date supplied by patient: or (3) under the following condition(s):

Date:	**Signature of Patient or Person Authorized to Sign for Patient**

FOR VA USE ONLY

IMPRINT Patient Data Card (Name, Address, Social Security Number)

Type and Extent of Material Released

Date Released	Released By:

VA FORM 10-5345 (R) (663 Automated)

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 Regional Veterans Court	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:

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: Public Defense	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:
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If Appropriate-

Parent/Guardian Signature: ***Date:*** / /

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

Sound Mental Health

MRN:

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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: WA-Department of Veterans Affairs	Organization:
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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: