**CONSENT FOR SUBSTANCE USE DISORDER CLIENT LOOKUP**

**King County Behavioral Health Organization**

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

FAX: 206-205-1634



**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the King County Behavioral Health Organization (KCBHO) to make available to the substance use disorder programs and mental health programs participating in the King County Behavioral Health Organization Network and state contracted Medicaid Managed Care Organizations (MCOs) that provide your physical health care (your provider will provide *a list of the KC BHO programs and current MCOs*) for the purpose of coordinating my substance use disorder, mental health treatment and physical health care the following information:

Name and other identifying information (such as DOB, gender, race), ProviderOne ID, disabilities, diagnosis, case manager name and contact information, where and when I was enrolled and received substance use disorder and/or mental health treatment services within the KCBHO network.

**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 actions that have already been taken based on the original authorization.
* Without my express revocation, this consent will expire upon the completion of treatment and exit from the KCBHO network; unless I am under the supervision of the Washington State Department of Corrections at the time of exit from KCBHO, then this authorization will expire at the end of the term of supervision.
* 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 CFR Part 2.
* I will not be denied services funded by the KCBHO network 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.”

***For Program Use Only:*** *The client chooses not to sign this form.*

*Staff signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*