VALLEY | CITIES
Behavioral Health Care

# RELEASE OF INFORMATION

**Return to:**
Medical Records
33405 8th Ave, S Suite 200
Federal Way, WA 98003

**Phone:** 206-408-5227
**Fax#** 253-835-9976
**Hours:** Monday-Friday
8:30am-5:00pm

**Client Information**

Name (please print full legal name): _____ Date of Birth: _____

Address: _____ Phone number: _____

**Request information from the listed person/ organization:**

Name of Person/ Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

**Disclose my information to the listed person/ organization:**

Name of Person/ Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

☐ **All Mental Health (MH) Records**
☐ **All MH Billing/Financial Records**
**Specific Dates of Service:**
**From** _____ **To** _____ **OR**
Most recent 1 year **(default if no dates listed)**

☐ **All Substance Use Disorder (SUD) Records**
☐ **All SUD Billing/Financial Records**
**Specific Dates of Service:**
**From** _____ **To** _____ **OR**
Most recent 1 year **(default if no dates listed)**

If ***ALL RECORDS*** are ***NOT*** needed, ***ONLY*** check items below:

| | | | |
|---|---|---|---|
| Assessment(s)/Update(s): ☐MH ☐SUD | Active Problem List (Diagnosis): ☐MH ☐SUD | Active Medication List: ☐MH ☐SUD | Lab/UA Results: ☐MH ☐SUD |
| Treatment Plan(s): ☐MH ☐SUD | Group Treatment: ☐MH ☐SUD | Individual Treatment: ☐MH ☐SUD | Psychiatric Evaluation: ☐MH ☐SUD |
| Scheduling/Appointment History: ☐MH ☐SUD | Family Treatment: ☐MH ☐SUD | Information Related to Peer Services: ☐MH ☐SUD | Psychiatric or Medical Notes: ☐MH ☐SUD |
| Case Management / Community Support: ☐MH ☐SUD | Discharge Summary(s): ☐MH ☐SUD | Crisis Plan: ☐MH ☐SUD | Status Reports for Court/Probation: ☐SUD |
| Verification Letter for Court: ☐MH | Wraparound Records: ☐MH | Completed DOL Online Form: ☐SUD | Certificate of Completion: ☐SUD |
| Employment Services Records: ☐MH | Housing Records: ☐MH | MAT Notes: ☐SUD | Other: ☐MH ☐SUD |

Other (specify):

_____

**Expiration: *Unless otherwise specified, the ROI will automatically default to expire on the date of discharge or 90 days after discharge for SUD programs that fall under 42 CFR Part 2.**

**Only** select if needed:

☐ Upon one-time release of the above information

☐ On this date: _____

**I understand that:**

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of record. (RCW 70.02.10 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 11.125.050).
- This authorization is my consent that allows Valley Cities to disclose information about my healthcare, mental health, substance use treatment, HIV/AIDS, and sexually transmitted diseases. These records are protected by state and federal law (RCW 70.02, RCW 70.24, 42 CFR Part 2, 45 CFR Parts 160 & 164) and cannot be shared without my written consent, except as permitted by law.
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Mental Health information, I must do so in writing. To revoke authorization to release Substance Use Disorder Program information, I may do so verbally to SUD clinical staff or program manager, or in writing.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by Federal Privacy Standards.

**Signature:**

**Client/ Legal Authority Signature:** _____ **Date:** _____

**Written Name of Client/Legal Authority:** _____

**If the authorization is signed by a Legal Authority of the individual, a description of such representative's authority to act for the individual must also be provided.**

**Relationship to Client:** _____

**Description of Legal Authority:** _____

SIGNATURE REQUIRED ABOVE

***REVOCATION***

You may revoke this authorization in writing. You may visit any Valley Cities Locations or obtain Revocation form under Resources (Medical Records) at https://www.valleycities.org/medical-records/ The revocation will be effective upon receipt and approval. Any information that has already been released or to services already provided according to this authorization will not apply.