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 expire on the date of discharge or 90 days after discharge for SUD programs that fall under 42 CFR Part 2.

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 Substance Use Disorder Program information, I may do this 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.

Instructions on Completing a Release of Information

Client Authorization to Send or Request Protected Health Information

Section #1 (Client Information): The legal name at time of information being requested, full address, birthdate, and phone number of the client.

Section #2 (Request information from the lister person/ organization) Note: All selections include verbal communication about the records requested. If email is selected, the client understands and accepts the potential risks of email communication.

Identify the Agencies who hold the health records that are being requested by Valley Cities. Name of person/ organization, phone number, email address, fax number to send request and address if no fax number is available.

Section #3 (Disclose my information to the listed person/organization) Note: All selections include verbal communication about the records sent. If email is selected, the client understands and accepts the potential risks of email communication.

Name of person/ organization, phone number, email address, fax number to send request and address if no fax number is available.

Section #4 Check boxes for which program/ record types are permitted for disclosure/request. Note: If this section is not completed with specific dates of services, only the previous 1 year from the date signed will be released.

- Select Mental Health records/ Mental Health Billing-Financial records with specific dates of service.
- Select Substance use disorder records/ Substance use disorder Billing-Financial records with specific dates of service.
- If **ONLY** Financial/ Billing records are needed. Then only fill out that section.
- If **ALL RECORDS are** needed to be processed *check off All Mental Health records* OR *ALL Substance use disorder records*. IF both Mental Health Records and Substance use disorder records are needed then select **BOTH boxes**.
- **Specific Dates of Service**: From to End- The date of what records need to be requested/ disclosed, if no dates are mentioned then only 1 year from consent date records will be requested or disclosed.
- If you **do not want to send ALL RECORDS**, then only check the items listed for the specific record type boxes.

Section #5 (Expiration) Page 2: Substance use disorder programs that fall under 42 CFR Part 2 will expire 90 days after discharge. Unless otherwise specified, all other programs release of information will automatically expire upon discharge.

Section#7 Signatures:

- A client aged 13 or older must sign this form unless authority has been legally assigned or designated to another individual.
- For clients younger than 13, the parent or legal guardian must sign on behalf of the client.
- For deceased clients, this form may be signed by the client's surviving spouse or personal representative (for example, administrator or executor of the estate).
- All individuals signing for, sending, or requesting healthcare information on behalf of a client must state their relationship to the client. Individuals will be required to provide proof of legal authority to permit the use of sending or requesting healthcare information.

If you have any questions or concerns, please contact the Medical Records Department at 206-408-5227.