Valley|Cities

REQUEST FOR THE RELEASE OF 42CFR PART2
SUBSTANCE USE DISORDER PROGRAM INFORMATION

AUTHORIZATION FOR USE AND DISCLOSURE OF SUD PROGRAM INFORMATION

Return to: MEDICAL RECORDS
33405 8TH Ave S, Suite 200
Federal Way, WA 98003

☏ (206) 408-5227
FAX (253) 835-9976

CLIENT'S FULL LEGAL NAME _____ CLIENT'S DATE OF BIRTH _____

CLIENT'S SOCIAL SECURITY NUMBER - IF AVAILABLE _____ CLIENT'S PHONE NUMBER _____

I HEREBY REQUEST VALLEY CITIES TO RELEASE MY RECORDS TO:

The following person or organization:

NAME OF PERSON OR ORGANIZATION _____ RELATIONSHIP TO CLIENT _____ PERSON OR ORGANIZATION'S PHONE / FAX # _____ / _____

PERSON OR ORGANIZATION'S FULL ADDRESS _____

Date Range to be included: **FROM:** _____ **TO:** _____

Types of Records: ☐ All SUD Program Records ☐ All Financial/Billing Records

Or only items checked:

- ☐ Assessment(s), Update(s)
- ☐ Crisis Plan
- ☐ Treatment Plan(s)
- ☐ Scheduling/Appointment History
- ☐ Discharge Summary(ies)
- ☐ Medical Initial and Followup Notes
- ☐ Medication Assisted Treatment Medical Notes
- ☐ Active Medications
- ☐ Active Problem List (Diagnoses)
- ☐ Laboratory Reports/Results
- ☐ Individual and Family Treatment
- ☐ Group Treatment
- ☐ SUD Progress Reports for Court/Probation
- ☐ Peer Services
- ☐ Case Management/Community Support
- ☐ Other (specify):_____

Additional Requests for Specific Sensitive Information Types

- ☐ I request the release of substance use disorder treatment and diagnosis information (required for ALL substance use programs)
- ☐ I request the release of mental health treatment information
- ☐ I request the release of information about sexually transmitted diseases
- ☐ I request the release of information about HIV or AIDS diagnoses or treatment
- ☐ I request the release of ***verbal information*** about my treatment

Additional Request for Information to be OBTAINED from the Above Named person or Organization

☐ I authorize the above named person or organization to ***send the records*** listed below to Valley Cities in order to coordinate my care and treatment services (**Describe as detailed as possible):**_____

_____

Expiration: (select one)

- ☐ 90 days after my discharge from Valley Cities SUD Program
- ☐ 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 7.70.068).
- Any records that contain information regarding mental health are protected by state law (RCW 70.02); HIV/AIDS or confirmed STD tests or treatment records are protected by state confidentiality laws (RCW 70.24). Substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- 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.

CLIENT SIGNATURE _____ RELATIONSHIP TO CLIENT _____

WRITTEN NAME _____ EFFECTIVE DATE FOR RELEASE _____

AUTHORIZED SIGNATURE IF NOT *SELF/CLIENT _____

Valley Cities ID# _____