

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

Phone: 206-408-5227
Fax: 253-835-9976
Hours:
 Mon-Th: 8:30am-6:30pm
 Friday: 8:30am-5pm

Client Information:

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

Address: _____ Phone number: _____

I would like to:

- Request Disclose Both request and disclose

My healthcare information to/from the following person or 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:

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

Other (specify): _____

SIGNATURE REQUIRED ON PAGE 2

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 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 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 or Disclose Information): Select if you would like to Request (ask for) information, Disclose (give out) information, or Both. Then, identify the Person or Organization the request or disclosure will be sent/given to. Include the Name of person/ organization, the phone number, the email address, and the fax number. Please include the address if no fax number is available.

Section #4 (Record Types): Check boxes for which program/ record types are permitted for disclosure/request. All selections include verbal communication about the content of the selected records. Note: If this section is not completed with specific dates of services, only the previous 1 year from the date signed will be released.

- 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**.
- If **ONLY** Financial/ Billing records are needed, then only fill out that section. You may also select this box if you would like billing records included with other records.
- **Specific Dates of Service:** Start Date to End Date: The date range of what records need to be requested/ disclosed. If no dates are provided, then only the previous 1 year of records from the consent date (date the client signs the ROI) 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 of 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