North Sound Mental Health Administration
117 North 1st Street, Suite 8
Mount Vernon, WA 98273
360-416-7013

AUTHORIZATION TO RECEIVE AND/OR RELEASE INFORMATION

Health information includes information collected from me or created by the agency, or information received by the North Sound Mental Health Administration (NSMHA) from a health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment of my health care services.

By signing this Authorization, I authorize the following person (s) and/or agency (s) the use or disclosure of my individually identifiable health information:

Name: _____ Address: _____

Institutional Affiliation: _____

I understand that the NSMHA is prohibited from disclosing information about treatment for psychiatric disorders/mental health, HIV/AIDS virus or sexually transmitted diseases and/or alcohol or drug abuse without my specified written authorization, unless a disclosure is otherwise authorized by law. I understand that my records are protected by Washington State laws, and Federal Privacy and Confidentiality Rules (42 CFR Part 2, 45 CFR).

Health information that may be used or disclosed through this Authorization is as follows:

- ❑ All Health information about me, including my clinical records, created or received by the Provider. This information may include, if applicable: information pertaining to the identity, diagnosis, prognosis or treatment for psychiatric disorders/mental health, HIV/AIDS virus or sexually transmitted diseases and/or alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse programs; or;

- ❑ All health information about me as described in the proceeding check box excluding the following:

_____

_____

- ❑ Specific health information including only:

_____

_____

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

The purpose(s) of this Authorization is (are):

_____

(This may be left blank if the request for information has been initiated by the client and the client does not elect to disclose its purpose, unless the information pertains to alcohol or drug abuse identity, diagnosis or treatment.)

I understand that the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party because the Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I understand that, except when I am (i) receiving research-related treatment, (ii) receiving health care solely for the purpose of creating information for disclosure to a third party, (iii) enrolling in the health plan or seeking eligibility for benefits, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from the NSMHA.

I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before the Provider receives written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Office at the North Sound Mental Health Administration. The address of the Privacy Office is: 117 N. First St., Suite 8, Mount Vernon, WA 98273

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Signature of Client: _____ Date of Signature: _____

Print Client's full name: _____

Client's home address: _____

Client's home telephone: _____ Date of Birth: _____

When client is not competent to give consent, the signature of a parent, guardian, or other authorized legal representative is required.

Signature of legal representative: _____ Date of signature: _____

Print name: _____

Relationship of representative to client: _____

Witness: _____

Substance Abuse Redisclosure Notice, North Sound Mental Health Administration
117 North First St., Suite 8, Mount Vernon, WA 98273
Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.

This information has been disclosed to you from records protected by federal confidentiality rules governing federally assisted drug or alcohol abuse programs (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 is 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 consumer.