Kitsap Mental Health Services
5455 Almira Dr. NE, Bremerton, WA, 98311 Main Phone: (360) 373-5031
Clinical Records Phone: (360) 415-3940 Clinical Records Fax: (360) 373-0917

Authorization to Release-Obtain Information

1 Client Name: _____ Date of Birth: _____

I authorize Kitsap Mental Health Services to exchange information (as indicated in sections 6-12) with the following entity/individual(s):

2 Entity Name (if applicable): _____

3 Individual(s): _____

4 Relationship(s): _____

5 Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

6 I authorize the following information to be *RELEASED*:

a) ☐ **ALL of my MENTAL HEALTH information in my entire record.**

b) ☐ **ALL of my SUBSTANCE USE information in my entire record.**

c) ☐ **The specific information selected below. (Must check MENTAL HEALTH and/or SUBSTANCE USE box(es) below.)**

I authorize ☐ MENTAL HEALTH and/or ☐ SUBSTANCE USE information to be released if contained in selection(s) below:

☐ **Diagnostic Summaries**	☐ **Psychiatric Evaluations**	☐ **Appointments/Attendance**
☐ **Intake Assessments**	☐ **Clinical Progress Notes**	☐ **Treatment Verification/Compliance Reports**
☐ **Substance Use Assessments**	☐ **Medical Progress Notes**	☐ **Financial**
☐ **Discharge Summaries**	☐ **Medications/Prescriptions**	☐ **Other:** _____
☐ **Service/Treatment Plans**	☐ **Labs/Test Results**	☐ **Other:** _____

7 I authorize the following information to be *OBTAINED*:

a) ☐ **ALL of my MENTAL HEALTH information in my entire record.**

b) ☐ **ALL of my SUBSTANCE USE information in my entire record.**

c) ☐ **The specific information selected below. (Must check MENTAL HEALTH and/or SUBSTANCE USE box(es) below.)**

I authorize ☐ MENTAL HEALTH and/or ☐ SUBSTANCE USE information to be obtained if contained in selection(s) below:

☐ **Diagnostic Summaries**	☐ **Psychiatric Evaluations**	☐ **Appointments/Attendance**
☐ **Intake Assessments**	☐ **Clinical Progress Notes**	☐ **Treatment Verification/Compliance Reports**
☐ **Substance Use Assessments**	☐ **Medical Progress Notes**	☐ **Financial**
☐ **Discharge Summaries**	☐ **Medications/Prescriptions**	☐ **IEP (Individualized Education Program/Plan)**
☐ **Service/Treatment Plans**	☐ **Labs/Test Results**	☐ **Other:** _____

8 ☐ **I authorize KMHS to release and/or obtain HIV/AIDS/STD information.**

9 **I authorize ALL EPISODES OF CARE (OR)** Service Dates from: _____ through: _____

10 **I authorize KMHS to use/exchange my health information for the purpose of evaluation, treatment planning, service coordination, monitoring, and treatment referral (OR)** for a different purpose specified here: _____

11 I understand that my substance use treatment records are protected under federal regulations governing the confidentiality of substance use patient records 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Persons receiving confidential information may not further disclose such information if the information concerns substance use or treatment. However, I also understand that persons receiving other types of confidential information may have the ability to disclose the information as allowed by relevant state law and federal regulations. In that case, and to the extent that such re-disclosure may take place, this information will no longer be confidential. I understand that if I authorize disclosure using a general designation, that I will be provided a list of entities to which my information has been disclosed. I understand that I will not be denied services if I refuse to sign an authorization to release information and that I may revoke this authorization verbally or in writing except to the extent that action has already been taken in reliance on it. **THIS AUTHORIZATION EXPIRES:**

12 Select one: (a) ☐ **ANNUALLY** (Expires 1 year from signature date) **(OR)** (b) ☐ **TIME-LIMITED** (Expires 90 days from signature date) **(OR)** (c) ☐ **ALTERNATE DATE or EVENT** specified by client: _____

13 Signature of Client: _____ Date: _____

14 If signing below on behalf of client, please check the basis for your authority. Documentation proving authority may be required.

☐ **Parent of Minor** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other Authorized Representative** _____

15 Signature of Authority: _____ Date: _____

16 Printed Name of Authority (or Witness if signatory below): _____

17 Signature of Witness (if client signs by mark): _____ Date: _____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 2.12(c)(5) and 2.65.

18 STAFF RECEIVING AUTHORIZATION (Printed): _____ **CLIENT ID**: _____

Kitsap Mental Health Services

Authorization to Release-Obtain Information: Form Completion Instructions

1 Print first and last name and date of birth.

If you want KMHS to release information to and/or obtain from, an Entity:

2 Print the name of the Entity (agency, business, government office, medical office, etc.).
3 Print N/A for Individual.
4 Print N/A for Relationship.
5 Print the complete mailing address, city, state, zip code, phone number and fax number of the Entity.

If you want KMHS to release information to and/or obtain from, an Individual:

2 Print N/A for Entity Name.
3 Print the first and last name of the individual that you want KMHS to release information to and/or obtain from.
4 Print the individual's relationship to you. Some examples are mother, spouse, friend, landlord, etc.
5 Complete as much of the mailing address, city, state, zip code, phone number and fax number as you can. Print N/A or UNK on a line if the information is not applicable or unknown.

6 If you want KMHS to RELEASE information from your clinical record, CHECK (a) All Mental Health **and/or** (b) All Substance Use **and/or** (c) Specific. If you select (c) "Specific Information" CHECK the box(es) authorizing Mental Health **and/or** Substance Use information **and** CHECK the box(es) for each type of information you want released.
Do not check (a) All Mental Health and also (c) Specific Information Mental Health.
Do not check (b) All Substance Use and also (c) Specific Information Substance Use.

7 If you want KMHS to OBTAIN information from your clinical record, CHECK (a) All Mental Health **and/or** (b) All Substance Use **and/or** (c) Specific. If you select (c) "Specific Information" CHECK the box(es) authorizing Mental Health **and/or** Substance Use information **and** CHECK the box(es) for each type of information you want obtained.
Do not check (a) All Mental Health and also (c) Specific Information Mental Health.
Do not check (b) All Substance Use and also (c) Specific Information Substance Use.

8 If you want KMHS to release and/or obtain HIV/AIDS/STD information, CHECK the box.
9 If the timeframe for the information you want released and/or obtained is different than ALL EPISODES OF CARE, fill in the specific SERVICE DATE RANGE that you authorize.
10 If the purpose of this authorization is something other than what is listed, write in the reason. Some examples are emergency contact, appointment scheduling, benefits, legal, court compliance, inpatient visits and/or phone calls, etc.

11 Read this section. It contains information about the confidentiality of your health care information as it relates to disclosure and re-disclosure as well as some of your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2 which governs substance use patient records.
12 Select the expiration date for the authorization by checking **one** of the following boxes:
(a) Annually (expires one year from signature date).
(OR) (b) Time-Limited (expires 90 days from signature date).
(OR) (c) Fill in an alternate date or event.

13 Sign and date this line if you are the client acting on your own behalf (age 13 and older).
Regarding minors: A minor's signature is REQUIRED in order to release information concerning that minor's mental health or substance use treatment if that minor has reached his or her thirteenth birthday. A minor's signature is REQUIRED in order to release information regarding that minor's sexuality, including but not limited to information concerning HIV/AIDS, contraception, pregnancy and/or termination of a pregnancy, sterilization, and sexually transmitted diseases if that minor has reached his or her fourteenth birthday.
14 If signing on behalf of the client, check the box that corresponds with your authority to sign the authorization.
Legal documentation proving authority (such as Guardianship, Durable Power of Attorney, Court Order, etc.) may be required in order to sign on client's behalf.
15 Signature and date of Authority (Parent of Minor, Guardian, Power of Attorney, Other Authorized Representative).
16 If signing as Authority or Witness, print first and last name.
17 Signature and date of Witness required if client signs by mark (instead of signing name).

18 Staff receiving authorization from client and forwarding to the Records department will **review for accuracy and completeness**, **provide assistance to individual as needed**, **print first and last name**, **and fill in client ID number**.