OLYMPIC HEALTH & RECOVERY SERVICES

RECORDS REQUEST
CLIENT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name:_____ Birthdate:_____

Other Names Used:_____ Phone Number:_____

Ok to contact this number regarding request: ☐ Yes ☐ No

Address:_____ State:_____ Zip Code: _____

*I authorize Olympic Health & Recovery Services to release records or information that I have identified below to the following person (If you are a client requesting your records list your information below):

Name of Person/Organization: _____

Address:_____ State:_____ Zip Code: _____

Dates of Records Being Requested:_____ Type of Records Being Requested (check all that apply):

Mental Health

☐ Outpatient mental health (i.e., assessments, progress notes, etc.)

Substance Use Disorder

☐ Outpatient substance use disorder (i.e., assessment, progress notes, etc.)

Crisis Stabilization Services Only

☐ Crisis Stabilization Services

I understand that OHRS will not release my record(s) to anyone else unless I have authorized. I understand that my authorization will remain in effect for 90 days from the date signed and that the information will be handled confidentially in compliance with all applicable laws. I understand that I may see or be informed of the information that is sent and that I may revoke the authorization at any time by written, dated communication.

Prohibition on Re-Disclosure

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse 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. My mental health / substance use disorder records are protected under Federal and State Confidentiality Regulations (42 CFR Part 2, "HIPAA" and WAC 388-877) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Unauthorized re-disclosure by recipient is prohibited. I also understand that I may revoke this consent at any time.

_____ _____

Client Signature Date of Signature

_____ _____

Parent/Guardian/Legal Representative Signature Date of Signature

FOR AGENCY USE ONLY

Verification Method (To verify identity of individual who records are being released to)

Verifying Information: Client Third Party (Attorney, MedicalProvider, etc.): _____

Phone Verification:_____ Drivers License/State ID: State: _____ Number: _____

Other: _____