CLIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name:_____ Birthdate:_____

Other Names Used:_____ Phone Number:_____

Ok to contact phone number related to requested disclosure? Yes □ No □

Address:_____ City:_____ State: _____ Zip Code: _____

*I authorize Olympic Health & Recovery Services ("OHRS") and Thurston Mason Behavioral Health Administrative Services Organization ("TM BH ASO") (collectively, the "Providers") to exchange the records that I have identified below with the following person/organization:

Name of Person/Organization: _____

Address:_____ City:_____ State:_____ Zip Code: _____

Type of Records Being Exchanged (check all that apply):

Outpatient Mental Health

- ☐ Intake Forms
- ☐ Medical History and Assessments
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Other: _____
- ☐ All Medical Records

Substance Use Disorder

- ☐ Intake Forms
- ☐ Medical History and Assessments
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Other: _____
- ☐ All Medical Records

Crisis Stabilization Services Only

- ☐ Records limited to crisis stabilization services

Other Protected Health Information

- ☐ Description: _____

Date Range for Records Being Exchanged:_____

Purpose for Exchange of Records: _____

I understand that the categories of health information above may contain information about my testing, diagnosis, and treatment for sexually transmitted diseases, mental health conditions, and/or substance use disorders. By my signature below, I specifically authorize the Providers and the person/organization identified above to exchange such information with each other in accordance with this Authorization. I understand that my alcohol and/or drug treatment records maintained by the Providers and/or the person/organization identified above may be protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless permitted by the regulations.

I understand that I may revoke this Authorization at any time by written, dated communication to OHRS Privacy Officer (Chris.Foster@tmbho.org), but that my revocation of this Authorization will not affect any actions already taken by the Providers and the person/organization identified above based on this Authorization. I understand that information disclosed under this Authorization might be redisclosed by the recipient and may no longer be protected by privacy laws.

I understand that this Authorization is voluntary, and that the Providers and the person/organization identified above will not condition my treatment, payment, or enrollment or eligibility for benefit on whether I sign this Authorization. I have been provided a signed copy of this Authorization.

This Authorization will expire on this date: _____ or within one (1) year if no date provided.

By my signature below, I certify that I am 13 years of age or older, I have read this Authorization before signing, I fully understand the contents, meaning, and impact of this Authorization, and have had all of my questions answered.

_____ _____

Client Signature Date of Signature

If client under the age of 13:

_____ _____

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, Medical Provider, etc.): _____

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

Other: _____