



CLIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION



OLYMPIC HEALTH & RECOVERY SERVICES

Client Name: Birthdate:

Other Names Used: Phone Number:

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

Address: 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: State: Zip Code:

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

Outpatient Mental Health

Substance Use Disorder

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

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

Crisis Stabilization Services Only

Other Protected Health Information

Records limited to crisis stabilization services

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 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 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.

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: