Authorization to Obtain/Release Confidential Information

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Treatment Services
(253) 649-1406, Fax (253) 649-1381

I, _____, authorize Tacoma Pierce County Health Department Treatment Services to disclose or exchange information with the following person or organization:

_____

(Name of person or organization to which disclosure is to be made)

Initial highlighted areas below:

___ The fact I am or was a patient of Treatment Services
___ Intake, assessment and collateral information
___ Discharge information, summary/ aftercare plan
___ Other (specify) _____

____ Treatment Plans
____ Progress notes, reports, information
____ All health care information in my medical record
____ Urinalysis results

Initial highlighted areas below:

The purpose of the disclosure and/or exchange of information is to:

___ Coordination with treatment
___ Reporting Progress and compliance
___ Evaluating patient for services, benefits or treatment
___ At my request

Contact Person

Name _____

Address _____

Phone _____ Fax _____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations or other law. Federal rules prohibit any further disclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F. R. Parts 160 & 164. I further understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. However, in emergency medical situations, information may be disclosed to ensure continuity of care. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

Federal laws and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or any threat to commit such crime.

Federal laws and regulations may not protect any information about suspected child abuse or neglect from being reported under State Law to the appropriate state or local authorities.

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below:

Except for court ordered treatment this consent will expire 60 days after discharge from treatment or upon the expiration date stated below (whichever comes first). Consents to release information to employers or financial institutions for purposes other than payment will expire in 90 days. For those under Department of Corrections supervision with court ordered treatment, this release will expire at the end of the term of supervision or 60 days following discharge for treatment (whichever is later). The expiration date of this consent must last no longer than reasonably necessary to serve the purpose for which it is given and term at end of service noted.

Patient Signature: _____ Authorization Date: _____

Expiration Date (if applicable): _____ Witness: _____