



Authorization For The Release Of Specially Protected Confidential Information

Name

Consumer Number

Date of Birth

I authorize release of information about my Mental Health, Chemical Dependency, STD/HIV/AIDS Care in the following circumstances:

- The agency or provider named below requests information from Group Health.
Group Health requests information from the agency or provider named below.
A mutual exchange of information between Group Health and the agency or provider named below.

Agency, Provider, or Other Entity: Name and Address:

Behavioral Health Services, Group Health Cooperative: Name and Address:

Blank lines for Agency, Provider, or Other Entity name and address.

Blank lines for Behavioral Health Services, Group Health Cooperative name and address.

Phone/FAX #:

Phone/FAX #:

Information may be faxed

PURPOSE OF DISCLOSURE: Continuing Care, Legal, Insurance, At Patient Request for Patient Use, Other

This authorization also applies to:

- evaluation; treatment; treatment recommendations; treatment plans; progress toward treatment goals; case management; referral authorization information; family involvement and participation in treatment/detox; Progress Reports for Criminal Justice System; Progress Reports for EAP's; Discharge and Transfer of Care Summary

which includes TB testing information; and Other (specify)

For service dates, from to

I understand that my records are protected under federal and state confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for by law.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form, DM-3523, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by Group Health based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once Group Health has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires (date or event). Authorization will expire in ninety days if not otherwise specified.

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Date, Signature of patient or patient's authorized representative, Relationship to patient if not patient, Check if patient is a minor

**DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION:**

Federal regulations (42 CFR part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by law. A general authorization for the release of information is NOT sufficient for this purpose.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

**MENTAL HEALTH INFORMATION:**

State law prohibits any further disclosure of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 71.05 and RCW 71.34.)

**SEXUALLY TRANSMITTED DISEASE INFORMATION:  
(includes HIV/AIDS)**

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 70.24)

**CONSENT OF MINOR (age 13 and above for outpatient Drug and Alcohol, and/or Mental Health Information, age 14 and above for Sexually Transmitted Disease Information (including HIV/AIDS):**

A minor patient's signature is required in order to release information concerning care for: 1) pregnancy termination and sexually transmitted diseases; 2) alcoholism or drug abuse; and 3) mental health conditions.

**TO BE COMPLETED BY GHC**

Date Received \_\_\_\_\_ Charge \_\_\_\_\_

Date Sent \_\_\_\_\_ Paid \_\_\_\_\_

**Information Released:**

MH / CD (*circle one*)

**DATES:** From / To

- Visit Note(s) \_\_\_\_\_
- Consultations \_\_\_\_\_
- Reports \_\_\_\_\_
- Tools \_\_\_\_\_
- Laboratory Reports \_\_\_\_\_
- Medications \_\_\_\_\_
- Discharge Summary \_\_\_\_\_
- Correspondence \_\_\_\_\_

**Provider Review:**

- Ok to release requested information
- Not approved for release

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

**Copied By:** \_\_\_\_\_

**Sent By:** \_\_\_\_\_