AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE KIDS' MENTAL HEALTH PIERCE COUNTY COMMUNITY COLLABORATION

Name_____ **Date of Birth**_____

By signing below, I authorize the Community Collaboration Workgroup, which includes staff from the following entities:

CHI Franciscan	Central Pierce, East Pierce, Gig Harbor, Graham, Orting and West Pierce Fire Districts	Puyallup Tribal Health Authority	Amerigroup
Beacon	Multicare	A Common Voice	Coordinated Care
Comprehensive Life Resources	Behavior Bridges	Molina Healthcare	Pierce County Juvenile Court
Greater Lakes Mental Healthcare	Developmental Disabilities Administration (DDA)	United Healthcare	Department of Child, Youth and Families
SeaMar	Catholic Community Services	Consejo	Other:

To communicate with and disclose to one another the following information *(Please check all appropriate boxes):*

- ☐ Initial and subsequent evaluations of my service needs by the Community Collaboration and its members
- ☐ Current and past Mental Health Treatment Programs, with dates
- ☐ Current and past Substance Use Disorder Treatment Programs, with dates
- ☐ Current and past Emergency Department visits, with dates
- ☐ Past or present Mental Health Problems or Diagnosis
- ☐ Past or present Substance Use Disorder Problems or Diagnosis
- ☐ Past or present Physical Health Problems
- ☐ Other: _____

The purpose of the release/disclosure is to coordinate the following treatment activities: *assessment, referral, medical, substance use disorders, mental health, vocational, shelter or housing services.*

By signing this authorization, I understand the following:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. Any revocation will not take effect if action has already been taken based on the original authorization. Without my express revocation, this authorization will expire in one year from the signature date below.
- The information disclosed and redisclosed may contain information on my current/past: Mental Health, substance or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by, with the exception of, Substance Use Disorder records which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2.
- I understand that this authorization is voluntary and that I may refuse to sign this form. My refusal to sign will not affect the treatment or services I receive from specific providers but will limit the ability of the workgroup members to discuss my needs and to coordinate my care.

Signature (Patient or Person Authorized to give authorization) **Date**

_____

If signed by person other than patient, please print your name, provide reason, relationship to patient, & description of authority

All disclosures and redisclosures must be accompanied by the following notice: "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."