



# RELEASE OF INFORMATION

<b>Client Name/ID/DOB</b> (or affix label) _____	Previous/Maiden Name or Alias: _____
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<b>COMPASS HEALTH</b> Address: <u>PO Box 3810, M/S 07</u> <u>Everett, WA 98213</u> Phone: _____ Fax: _____ Attn: <u>Health Information Management</u>	Compass Health may <input type="checkbox"/> Disclose <input type="checkbox"/> Receive <input type="checkbox"/> Exchange the protected health information indicated below with: Person or Facility: _____ Address: _____ Phone: _____ Fax: _____
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I authorize the release of **any and all of the following medical, mental health and/or substance use disorder information, as specified**, which may be contained in my records (Check all that apply) with the following date parameters:

All Dates - or - Date Range: \_\_\_\_\_

<input type="checkbox"/> Behavioral Health Diagnoses <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Psychiatric Evaluations <input type="checkbox"/> Substance Use Disorder Assessments <input type="checkbox"/> Treatment/Crisis Plans <input type="checkbox"/> Treatment Plan Reviews <input type="checkbox"/> Psychiatric Treatment Notes	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Listing of Services Provided <input type="checkbox"/> Compliance Reports <input type="checkbox"/> Medication Summary <input type="checkbox"/> Nursing Assessments <input type="checkbox"/> History and Physical <input type="checkbox"/> Medical Diagnoses <input type="checkbox"/> Medical History/Profile	<input type="checkbox"/> Lab Results <input type="checkbox"/> Drug Screen Results <input type="checkbox"/> Substance Use Abstinence Status <input type="checkbox"/> Attendance Records <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Wise Child & Family Team Meeting Minutes <input type="checkbox"/> Wise Cross System Care Plan <input type="checkbox"/> Other (specify): _____
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**Purpose of this Disclosure:** (check all that apply)

<input type="checkbox"/> Assisting in diagnosis and treatment <input type="checkbox"/> Assuring continuity of care <input type="checkbox"/> Treatment planning <input type="checkbox"/> Coordinating care/service delivery <input type="checkbox"/> Report on progress <input type="checkbox"/> Referral for other treatment <input type="checkbox"/> Inform others of treatment status	<input type="checkbox"/> Verify compliance <input type="checkbox"/> Legal Consult/hearing <input type="checkbox"/> Determine disability <input type="checkbox"/> Vocational <input type="checkbox"/> At the request of the individual <input type="checkbox"/> Educating natural supports about behavioral health issues <input type="checkbox"/> Other (specify): _____
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I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	<input type="checkbox"/> Approve <input type="checkbox"/> Deny
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As the individual signing, I understand the terms of this Authorization, including:

1. I am giving my permission to Compass Health to disclose my confidential health records.
2. That my signing of this Authorization is voluntary.
3. My health information is protected by federal HIPAA Privacy regulations.
4. If the organization authorized to receive the Information is not a health plan, healthcare clearing house or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
5. Staff of Compass Health may not condition treatment, payment, or enrollment on the signing of this Authorization.
6. A photocopy of this Authorization is as valid as the original, and that I am entitled to a copy of this Authorization. Compass Health reserves the right to utilize any and all secure methods for releasing the information specified above.
7. Paper or electronic copies of my records may be used to facilitate disclosure of my information.
8. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing.
9. I understand that I have the right to refuse to sign this Authorization.
10. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.

This Authorization is effective (date): \_\_\_\_\_

**Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from services at Compass Health, whichever is later.**

NOTICE: Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

\_\_\_\_\_  
Signature of client, or client's parent/guardian/legal representative

\_\_\_\_\_  
Date

(Office Use Only) Document was provided to the client in an alternative language