

MultiCare Behavioral Health

(Medical Record Location) 325 E. Pioneer, Puyallup, WA 98372

Medical Records Phone: 253-697-8530

Medical Records Fax: 253-697-8393

I authorize Multicare Behavioral Health (MBH) to:

**** Must list COMPLETE address (this INCLUDES requests for VERBAL exchange)****

<input type="checkbox"/> Exchange information verbally with:	Name: _____	<input type="checkbox"/> PCP
<input type="checkbox"/> Send my Behavioral Health records to:	Address: _____	
<input type="checkbox"/> Request records from listed provider:	Phone #: _____	or fax #: _____

<input type="checkbox"/> Exchange Information by E-Mail	<input type="checkbox"/> I have reviewed the E-Mail Statement of Understanding and Consent Form with my therapist.
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Email Address: _____

Type of Information to be disclosed:

<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Medical Records	<input type="checkbox"/> PCP MH Advisory Letter
<input type="checkbox"/> School Records	<input type="checkbox"/> MH Scheduling Information	<input type="checkbox"/> Participation in MH Therapy Sessions
<input type="checkbox"/> Other (must specify): _____		

Information to be released is concerning (List name if not client):

<input type="checkbox"/> Myself	<input type="checkbox"/> Adult Client for whom I am POA, DPOA or Legal Guardian, Legal Next of Kin
<input type="checkbox"/> Minor Child for whom I am Parent or Guardian	Printed name of person completing this form: _____

Purpose for Release is for CONTINUITY/Coordination OF CARE unless otherwise specified:

<input type="checkbox"/> Other (must specify): _____
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- I understand that my records may contain protected information regarding the testing, diagnosis and/or treatment for mental health or psychiatric treatment, HIV (AIDS virus), or other sexually transmitted diseases, drug and alcohol treatment.
- I understand that my records are protected under Washington State Law 70.02 and by HIPAA federal regulation 45 CFR, Part, 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that the information disclosed may be subject to re-disclosure by the intended recipient and will no longer be protected by federal privacy laws or regulations.
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Multicare Behavioral Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment or payment, on my behalf unless an authorization for disclosure is required in order for Multicare Behavioral Health to receive third party payment for services rendered.
- A copy or fax of this document shall be considered valid in lieu of the original.

I understand that there may be a fee charged for copies of my records as set by WAC 246-08-400

This authorization **EXPIRES** 180 days after date signed unless one of the below boxes is marked.

<input type="checkbox"/> 30 Days after termination of services at MBH
<input type="checkbox"/> List other specified DATE: _____

Signature (Client or legal guardian): _____	DATE: _____
Printed Name: _____	Relationship to client: _____
<input type="checkbox"/> Myself (13 or older) <input type="checkbox"/> Parent <input type="checkbox"/> DPOA <input type="checkbox"/> Legal Healthcare Guardian, Legal Next of Kin	

Client Name: First	MI	Last	DOB: _____	CLIENT ID# _____
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Authorization to Use or Disclose Health Information