MultiCare *(Medical Record location)* **325 E. Pioneer, Puyallup, WA 98372**

Substance Use Disorder Services (Puyallup/Tacoma) **Medical Records Phone: 253-697-8530**

Medical Records Fax: 253-697-8393

I authorize MultiCare Substance Use Disorder (SUD) Services to:

☐ **Exchange information verbally with:**

☐ **Send my SUD Services records to:**

☐ **Request records from listed provider:**

Name:	
Address:	
Phone #:	or fax #:

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

Type of Information to be disclosed:

☐	**Intake**	☐	**Substance Use Assessment**	☐	**Phone Contact-Verbal Collaboration**
☐	**Clinical Progress Notes/Group Notes**	☐	**SUD Assessment Summary**	☐	**Treatment Compliance Report**
☐	**Treatment Plan**	☐	**List of Medications**	☐	**Treatment Recommendations**
☐	**Termination/Discharge Summary**	☐	**Other (I.E. Target):**		

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

☐	Myself	☐	Adult Client for whom I am POA, DPOA or Legal Guardian, Legal Next of Kin

Print **YOUR** name if **YOU ARE NOT** the client:_____

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

☐	Facilitate treatment Planning	☐	Enable Transfer of Services
☐	Medical Planning	☐	Condition of Court Order/Parole
☐	Other:		

- 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 my records are protected under Washington State Law 70.02 and by HIPAA federal regulation 45 CFR, Parts 160 and164 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 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 Chemical Dependency Services. 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 Chemical Dependency Services 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 30 DAYS** after termination of services at MBH,
UNLESS I specify another date HERE: _____

Signature (Client or legal representative):	DATE:
☐Myself (14 or older) ☐DPOA ☐Legal Healthcare Guardian, Legal Next of Kin	
Printed Name:	Relationship to client:

Client Name:	First	MI	Last	DOB:	CLIENT ID#

Authorization to Use or Disclose Health Information