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)*****

☐ **Exchange information verbally with:**	Name:	☐ **PCP**
	Address:	
☐ **Send my Behavioral Health records to:**		
☐ **Request records from listed provider:**	Phone #: or fax #:	

	Exchange Information by E-Mail		**I have reviewed the E-Mail Statement of Understanding and Consent Form with my therapist.**

Email Address: _____

Type of Information to be disclosed:

	Mental Health Records		Medical Records		PCP MH Advisory Letter
	School Records		MH Scheduling Information		Participation in MH Therapy Sessions
	Other (must specify):				

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
	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:

	Other (must specify):

- 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.

	30 Days after termination of services at MBH
	List other specified DATE:

Signature (Client or legal guardian):	DATE:
Printed Name:	Relationship to client:
☐Myself (13 or older) ☐Parent ☐DPOA ☐Legal Healthcare Guardian, Legal Next of Kin	

Client Name: First MI Last DOB: CLIENT ID#

Authorization to Use or Disclose Health Information