Community Integrated Health Services

Authorization to Use or Disclose Protected Health Information Form

Health information and records are protected by federal and state confidentiality laws and regulations and cannot be released without my written consent, unless otherwise provided for in those laws and regulations.

Authorization to Disclose or Exchange Information of:		
Name (first, middle, last)		Date of Birth
(Additional Information that may be helpful in locating records)		
Former Names		Identification Number
Disclose to and Exchange Information with:		
I hereby consent to disclosure and exchange of information among Community Integrated Health Services and the following agencies and individuals:		
Name (first, middle, last)		Title
Organization or Business Name (If applicable)		
Address (street, city, state, zip code)		
Phone (include area code)	Fax (include area code)	E-mail address
Purpose for disclosure **(required)**		

Information to be Disclosed and/or Exchanged:

I give permission to disclose the following information (initial each one that applies)

_____ Progress/Discharge Reports
_____ Psychological Test Results/Evaluation
_____ Psychiatric Evaluation
_____ Medication/Lab Reports
_____ Assessment/Diagnosis
_____ Other (specify): _____

_____ Treatment Plan
_____ Verbal Communication
_____ Alcohol and Drug use
_____ HIV/AIDS and STD results, diagnosis or treatment records (RCW 70.02.220)

Duration of Disclosure:

This consent is valid until _____ (must enter a date or event, such as discharge from services)

Authorization:

- I understand that my records may no longer be protected under the laws that apply to the releasing agency after this disclosure.
- A copy of this form is valid to give my permission to disclose records. Agencies may charge to provide copies of records.
- I may revoke or withdraw my permission in writing at any time. Information already disclosed or required by court order will not be affected.
- Refusal to sign his form may not be a basis to deny any service.

Signature	Date	Telephone number
Print Name	Witness/Notary (sign and print name if applicable)	

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of Minor ☐ Legal Guardian ☐ Personal Representative ☐ Other

Notice to those receiving information:

If these records contain information about HIV, STDs, alcohol or drug abuse, or protected health information, you may not further disclose this information under federal and state law without specific permission of the subject and meeting specific legal requirements.

Community Integrated Health Services, PO Box 1447, Chehalis, WA 98499 Phone: 360-261-6930 or 855-303-4834

Main/FACT Fax: 360-748-4480 or 844-554-3370 **Peer Bridgers Fax:** 360-719-1208 or 844-810-6423

Trueblood Fax: 360-356-1832 or 844-810-6422 **WISe Fax:** 360-558-7189 or 844-497-2430