Release of Protected Health Information

Stillaguamish Behavioral Health Program

Client Name:	DOB:

Who May Share My Information

I authorize Stillaguamish Behavioral Health Program (SBHP) to: ☐ Release ☐ Obtain or ☐ Exchange, protected health information as indicated below to/from/with:

Organization/Individual:		
Phone:	Fax:	City, State:

Notice to those receiving information: Under state and federal law, if these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information without specific written authorization of the person to whom it pertains.

Information I Agree to Share

Substance Use Disorder	Mental Health	Medical
☐ Diagnosis	☐ Diagnosis	☐ Diagnosis
☐ ASAM Assessment	☐ Assessment/Psychiatric Evaluation	☐ Chart Notes
☐ Assessment Summary	☐ Assessment Summary	☐ Medication Summary
☐ Treatment Recommendations	☐ Treatment Recommendations	☐ Laboratory Results
☐ Attendance/Participation	☐ Attendance/Participation	☐ HIV/AIDS test results or diagnosis
☐ Toxicology/ Drug Test Results	☐ Compliance/ Status Report	☐ Sexually Transmitted Infection Info.
☐ Compliance/Status Reports	☐ Discharge Summary	☐ Substance Abuse Treatment
☐ Discharge Summary		☐ Reproductive Care
☐ Appointment Schedule	☐ Other:	
Encounter Dates (if applicable):		

Purpose Of Disclosure

☐ Assist in Diagnosis and Treatment	☐ Coordination of Care	☐ Emergency Contact Notification
☐ Referral for Treatment	☐Report Progress/Verify Compliance	☐ Transportation Coordination
☐ Billing and/or Health Care Operations	☐ Other	

Consent Expiration

I understand that I can revoke my consent to share my information at any time. Information shared before I revoke my consent cannot be taken back. Consent will expire in one year if not otherwise indicated below.

My permission ends: ☐ On this date: ☐ Upon my death ☐ Upon my 18th birthday

Signature

Minors: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care; (2) sexually transmitted diseases (if age 14 and older); (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered. I understand that I do not need to sign this form to receive care or services.

Print Name of Person Giving Consent:	
Signature of Person Giving Consent:	Date:
Relationship to Client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Authorized Representative	

Revocation of Consent	
I revoke my consent to share the above information. My consent cannot be revoked to the extent it has already been acted upon.	
Signature:	Date:
FOR BHP STAFF ONLY: ☐ Consent was verbally revoked and client signature is unobtainable.	
Staff Name:	Date:

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