

Cowlitz 2

FIRE & RESCUE

I understand that my records are protected by Federal and State Confidentiality Laws and Regulations and cannot be released without my written agreement unless stated in those laws and regulations, e.g. in the case of a court order or to necessary medical personnel in a medical emergency. Federal regulations also prohibit any person from making further disclosure without my specific written consent. I also understand that I may cancel this consent in writing at any time unless action has already been taken based upon it, and that in any event, this agreement expires 90 days from the date of signing.

I understand that I agree to the release of records regarding mental health, alcohol/drug diagnosis and treatment, the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) by initialing the appropriate boxes below.

I understand that my right to confidentiality does not protect any information about a crime committed, or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical bodily harm, or that anyone else is in danger of physical bodily harm, that information is not protected.

It is with this understanding that I sign this form agreeing to the release of my records.

Client's Name: _____ DOB: _____ SS#: _____

Address: _____ Telephone Number: _____

I hereby authorize _____ to furnish/receive information listed below requested to/from the following agencies/individuals:

Name of Individual/Agency: _____

Address: _____

- Alcohol/Drug Diagnosis/Treatment
 HIV/AIDS/Sexually Transmitted Diseases
 Mental Health

PLEASE INITIAL AND DATE ALL THAT APPLY

Indicate information to be released:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Psychological Test | <input type="checkbox"/> Other (Specify): _____ | | |

For the purposes of:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Consultation/Referral | <input type="checkbox"/> Utilization Review | <input type="checkbox"/> Quality Assurance |
| <input type="checkbox"/> Resource Management <input type="checkbox"/> Other (Specify): _____ | | | |

This consent is subject to my revocation at any time except to the extent action has been taken in reliance thereon and unless earlier revoked, shall expire in 90 days from date of signature.

Client Signature _____

Date _____

Parent/Legal Guardian (if applicable) _____

Witness _____

Identification checked by _____
Initials of person checking

Date _____

I hereby revoke the above consent upon this day _____ recognizing action may have already taken place in accordance with this consent, for which I hold the above parties harmless.

"This information has been disclosed to you from records protected by federal confidentiality rules (42CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient."