Authorization to Release/Obtain/Exchange Protected Health Information

CLIENT NAME ______________________________ **DATE OF BIRTH** ______/______/______

I authorize *Tulalip Tribes' Child, Youth & Family (CYF) Mental Wellness* to

☐ Release Information to ☐ Obtain Information from ☐ Exchange Information with

The Following Organization/Individual

ORGANIZATION/INDIVIDUAL ______________________________ ATTN ______________

ADDRESS ____

CITY ______________________ STATE ________ ZIP ______________

PHONE (________) ________-__________ FAX (________) ________-__________

Receive the information requested by ☐ FAX ☐ MAIL ☐ PICK UP

Specific Information to be Released/Obtained/Exchanged

Requesting records from (MONTH/YEAR) ______________ **to** (MONTH/YEAR) ______________

☐ Behavioral Health Diagnoses
☐ Mental Health Assessment
☐ Individual Service Plan/Reviews
☐ Crisis Plan/Recommendations
☐ Progress Notes
☐ Transfer/Discharge Summary
☐ Compliance Reports
☐ Psychological Testing/Assessment
☐ Substance Use Disorder Assess./ Progress Notes
☐ Psychiatric Evaluations
☐ Medication management notes
☐ Current/Past medications
☐ Medical/Psychiatric History
☐ Developmental Evaluation
☐ Academic Progress/Concerns
☐ Education Testing/Records
☐ Individualized Education Plan (IEP) Record
☐ 504 Plan
☐ Family/Placement History
☐ Child welfare/CPS records
☐ Transportation
☐ Written and/or verbal communication re: appts.
☐ Other (please specify) ______________

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Purpose of Release/Obtain/Exchange of Information

☐ Participation in evaluation/treatment/coordination of care
☐ Transfer of care and/or referring to another agency/provider
☐ Legal
☐ Verify compliance
☐ Copies for own use
☐ Other (please specify) ______________________

[FOR CYF USE ONLY] If CYF is Obtaining Records, Send Records to

ATTN ____

☐ Tulalip Health System Electronic Health Record (Epic), Fax: (425) 259-8626
☐ Child, Youth & Family Mental Wellness Bldg.
See reverse side for clinic locations.
☐ Children's Advocacy Center (CAC)
☐ Karen I. Fryberg Tulalip Health Clinic – Behav. Health
☐ Betty J. Taylor Early Learning Academy (BJTELA)

Authorization

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can revoke this authorization at any time by contacting *Tulalip Tribes' Child, Youth & Family Mental Wellness.* I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- I have a right to receive a copy of this authorization.
- Current clients: This authorization will expire one year from the date signed below unless another date is entered here ______/______/______. Except if a client discharges from services, this authorization expires upon discharge.
- Non-current clients: This authorization will expire 30 days from the date signed below.

Release Requiring Specific Consent

I specifically authorize *Tulalip Tribes' Child, Youth & Family Mental Wellness* to release the information checked below:

☐ Sexually Transmitted Diseases (incl. HIV/AIDS) ☐ Reproductive Care ☐ Drug/Alcohol Abuse Treatment

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

Minor Signature

A minor client's signature is required in order to release the following information: 1) conditions related to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older), 2) mental health conditions (age 13 and older), and 3) drug and alcohol abuse diagnosis or treatment (age 13 and older).

SIGNATURE OF CLIENT	PRINTED NAME	DATE

Parent/Legal Guardian Signature

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE	
PRINTED NAME OF PARENT/LEGAL GUARDIAN	RELATIONSHIP TO CLIENT	(__________) __________-__________ PHONE NUMBER FOR LEGAL GUARDIAN

Guidelines for completing *Authorization To Release/Obtain/Exchange Protected Health Information*

Instructions to Staff:

- Check for completeness/legibility of key information:
  - Client information
  - Recipient's name and address
  - Clear indication of information being requested
  - Complete information about Child, Youth & Family Mental Wellness location (clinic or provider, for obtain portion)
  - Legal guardian/minor client's signature, and contact information
- Revocations/Changes
  - This is a legal document. Any change to this document, once the client/legal guardian has signed it, requires their initials and the date of the amendment as an indication of their approval for the change.
  - A revocation requires only that a line be drawn through the document, with the word "Revoked", and the date and time of revocation. The client/legal guardian need not initial a revocation. A client/legal guardian may request revocation by any means, including the telephone, provided their identity is confirmed.

Guidelines for Client/Families/Legal Guardians:

- Completing the form - Please make sure to complete all relevant sections of this form, including:
  - Client information
  - Organization/Individual contact name and address
  - Legal Guardian or client signature and contact information
- Where to take it or send it:
  - If you complete this form at CYF, give it to staff to forward to the appropriate personnel
  - If you are completing this form offsite, mail or fax the completed form to the appropriate CYF location *(see clinic locations below)*

Additional Information

Prohibition on Redisclosure of Confidential Information
Federal and state laws prohibit redisclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information, or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release for medical or other information is NOT sufficient for this purpose.

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), 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 as 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 abuse patient.

Clinic Locations

- **Child, Youth & Family Mental Wellness Bldg.**
  4033 76th Pl. NW Tulalip WA 98271, Ph: (360) 716-4224, Fax: (360) 716-0751
- **Children's Advocacy Center (CAC)**
  2321 Marine Dr Tulalip, WA 98271, Ph: (360) 716-5437, Fax: (360) 716-0852
- **Karen I. Fryberg Tulalip Health Clinic – Behav. Health**
  7520 Totem Beach Rd Tulalip, WA 98271, Ph: (360) 716-4511, Fax: (425) 259-8626
- **Betty J. Taylor Early Learning Academy (BJTELA)**
  7607 Totem Beach Rd Tulalip, WA 98271, Ph: (360) 716-4250, Fax: (360) 716-0811

CLIENT NAME/DOB/MRN
(or affix label)