ConsistentCare
Connecting People to Health

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Consistent Care Services may ☐ Disclose ☐ Receive ☐ Exchange the protected health information indicated here with the following providers: (please list all providers of care related to medical, mental health and/or substance use disorders)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

I authorize the release of any and all of the following medical, mental health and/or substance use disorder information, as specified, which may be contained in my records: (check all that apply):

☐ Mental Health Assessment	☐ Psychiatric Evaluations	☐ Behavioral Health Diagnoses
☐ Treatment/Crisis Plans	☐ Nursing Assessment	☐ Laboratory Results
☐ Progress Notes	☐ History and Physical	☐ Results of Urinalysis/Breathalyzer
☐ Progress Reports/Reviews	☐ Medical Diagnosis	☐ Attendance Records
☐ Substance Use Disorder Assessment	☐ Medical History	☐ HIV/AIDS/STD (requires initials below)
☐ Substance Use Abstinence Status	☐ Medications	☐ Discharge Summary
☐ Other _____	☐ Other _____	☐ Other _____

I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	Initials: _____

Purpose of this disclosure (check all that apply):

☐ Assisting in diagnosis and treatment	☐ Determining program eligibility
☐ Assuring continuity of care	☐ Coordinating service delivery
☐ Facilitating resident placement	☐ Referring to another agency/person
☐ Reporting to corrections office or court	☐ Educating natural supports about behavioral health issues
☐ Other _____	☐ Other _____

I understand that my records may contain information relating to mental health issues (per RCW 71.05.390) and or substance use disorders (42 CFR Section 2). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. I understand that Consistent Care Services cannot be held responsible for the disposition of the released information once disclosed to the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain enrollment with Consistent Care Services. Consistent Care Services reserves the right to utilize any and all secure methods for releasing the information specified above.

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from services at Consistent Care Services, whichever is later.

Patient Signature: _____ Date: _____

Please fax completed forms to (509) 371-1810