Salish Behavioral Health Administrative Services Organization
614 Division Street, MS-23 Port Orchard, WA 98366
P: 800.525.5637 | P: 360.337.7050

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION 1: PERSONAL INFORMATION
Individual Full Name:
Individual Date of Birth:

SECTION 2: WHAT INFORMATION AM I AUTHORIZING TO BE SHARED *(select all that apply)*

☐ Mental Health Treatment and Diagnostic Information

☐ Substance Use Treatment and Diagnostic Information

☐ Other (please specify)

SECTION 3: WHO CAN SHARE THE INFORMATION *(select all that apply)*

☐ Salish Behavioral Health Administrative Services Organization

☐ Other Treating Provider(s) (please specify below)

Provider Name	Provider Address	Provider Phone Number

SECTION 4: WHO CAN THE INFORMATION BE SHARED WITH *(select all that apply)*

☐ Salish Behavioral Health Administrative Services Organization

☐ Other Treating Provider(s) (please specify below)

Provider Name	Provider Address	Provider Phone Number

I understand that if the Recipient is not a health care provider or health plan, then the Health Information used and disclosed under this Release potentially may be shared or redisclosed by Recipient and may not be protected by federal or state privacy laws. When disclosing Health Information, Salish BH-ASO, if applicable, will send the attached notice with the Health Information. This notice informs Recipient that it is not allowed to disclose, without consent or

authorization by or on behalf of the Individual, certain Health Information, such as certain information concerning substance use disorder, AIDS, or sexually transmitted disease.

Note to receiving provider: **42 CFR Part 2 prohibits redisclosure of Substance Use Treatment Protected Health Information**

SECTION 5: WHY IS THE INFORMATION BEING SHARED *(select all that apply)*

☐ Coordination of care; including treatment, payment, referral, and operations

☐ Other (please specify):

SECTION 6: CONSENT EXPIRATION

I understand that my authorization will end: (*please select one*)

☐ On this date: _____

☐ One year from the date of my signature, or

☐ Upon my death

I understand that I have the right to revoke or take back this Release at any time, except to the extent that the Disclosing Entity already has taken action in reliance on this Release. I may take back or revoke this Release by contacting the Salish BH-ASO Privacy Officer. Generally, my revocation must be in writing, but a verbal revocation may be permitted for Health Information that involves certain substance use disorder information.

SECTION 7: SIGNATURE

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.**

Signature	Date
Printed Name of Individual giving consent	
Relationship to Individual	

☐ Self ☐ Parent ☐ Legal Guardian ☐ Authorized Representative