BRIDGES Behavioral Health Services
9004 Washington Ave. NW Silverdale, WA 98383
Phone: (360) 692-1582 Fax: (360) 692-1595

Authorization to Release-Obtain Information

1 Client Name:_____ Date of Birth:_____
I authorize Bridges Behavioral Health OMBUDS to exchange information (as indicated in sections 6-10) with the following individual/entity:

2 Individual:_____ Relationship:_____

3 Entity Name (if applicable):___NA_____

4 Entity Department (if Entity Name is listed):___NA_____

5 Address:_____

City/State/Zip Code:_____

Phone:_____ Fax:_____

6 By initialing on the corresponding line, I authorize Ombuds to release/obtain information related to the testing, diagnosis and treatment of the following type(s) of healthcare information: _____**MENTAL HEALTH** _____**SUBSTANCE USE** _____**HIV/AIDS/STD**

7 I authorize the information initialed below to be ***RELEASED*** to the person/entity named above:

_____ **Diagnostic Information**	_____ **Psychiatric Evaluations**	_____ **Substance Use Assessments**
_____ **Intake Assessments**	_____ **Medical Progress Notes**	_____ **Substance Use Tx Authorizations**
_____ **Discharge Summaries**	_____ **Medications/Prescriptions**	_____ **Substance Use Monthly Reports**
_____ **Service/Treatment Plans**	_____ **Labs/Urine Drug Screens/Test Results**	_____ **Appointment/Attendance**
_____ **Progress Notes**	_____ **Other:**_____	_____ **Financial**

8 I authorize the information initialed below to be ***OBTAINED*** from the person/entity named above:

_____ **Diagnostic Information**	_____ **Psychiatric Evaluations**	_____ **Substance Use Assessments**
_____ **Intake Assessments**	_____ **Medical Progress Notes**	_____ **Substance Use Tx Authorizations**
_____ **Discharge Summaries**	_____ **Medications/Prescriptions**	_____ **Substance Use Monthly Reports**
_____ **Service/Treatment Plans**	_____ **Labs/Urine Drug Screens/Test Results**	_____ **Appointment/Attendance**
_____ **Progress Notes**	_____ **Other:**_____	_____ **IEP (Individualized Education Plan)**

9 I authorize (initial one): _____**ALL EPISODES OF CARE (OR)** _____**Service Dates from:**_____ **through:**_____

10 Purpose of disclosure (initial one):

_____ I authorize OMBUDS to use/exchange my health information noted above for the purpose of evaluation, treatment planning, service coordination, monitoring, and treatment referral.

(OR)

_____ Other (list purpose): To have the Ombuds represent me through the grievance process.

11 I understand that information used/disclosed under this authorization may be disclosed verbally, electronically, or by hard copy or facsimile. A minor's signature is REQUIRED in order to release information concerning that minor's mental health or drug/alcohol treatment if that minor has reached his or her thirteenth birthday. A minor's signature is REQUIRED in order to release information regarding that minor's sexuality, including but not limited to information concerning HIV/AIDS, contraception, pregnancy and/or termination of a pregnancy, sterilization, and sexually transmitted diseases if that minor has reached his or her fourteenth birthday. I understand that the person that receives confidential information may not further disclose such information if the information concerns drug or alcohol use or treatment. However, I also understand that the person that receives other types of confidential information may have the ability to disclose the information as allowed by relevant state law and federal regulations. In that case, and to the extent that such re-disclosure may take place, this information will no longer be confidential. I further understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. Finally, I understand that I will not be denied service if I refuse to sign a release of information. **I have read this authorization or had it explained to me and I understand its contents.** This authorization expires as follows:

12 (Initial one): _____**ANNUALLY** (Expires 1 year from signature date) **(OR)** _____**TIME-LIMITED** (Expires 30 days from signature date)

(OR) _____**ALTERNATE DATE or EVENT** requested by client:_____

*****All authorizations will automatically expire 30 days after discharge from services*****

13 Signature of Client:_____ Date:_____

14 If signing below on behalf of client, please initial the basis for your authority. Documentation proving authority may be required.

_____**Parent of Minor** _____**Guardian** _____**Power of Attorney** _____**Other Authorized Representative**

15 Signature of Authority:_____ Date:_____

16 Printed Name of Authority (or Witness if signatory below):_____

17 Signature of Witness (if client signs by mark):_____ Date:_____

18 **Staff Receiving Authorization** (Printed):_____ **Client ID**:_____

Authorization to Release-Obtain Information
Form Completion Instructions

1. Print first and last name and date of birth.
2. Print the first and last name of the individual that Ombuds is authorized to exchange information with. Print the name of the individual or entity's relationship to the client (for example: mother, spouse, probation officer, PCP, etc.).
3. If applicable, print name of entity (name of agency, business, medical office, etc.).
4. If you list an entity name in #3, you must print the name of the entity department(s) in #4. You can list multiple departments, if applicable. Some examples are medical services, benefits, special services, administration, teachers, transportation, etc.).
5. Print mailing address, city, state, zip code, phone number and fax number of individual or entity.
6. Initial the line next to each type of information that you authorize to be released and/or obtained.
7. Select the information you authorize Ombuds to RELEASE from your clinical record by initialing the line next to each item that you choose.
8. Select the information you authorize Ombuds to OBTAIN from the individual or entity by initialing the line next to each item that you choose.
9. Select the timeframe for the information you authorize to be released or obtained. Initial the line next to "ALL EPISODES OF CARE" or, initial the line next to "SERVICE DATES" and fill in a specific date range.
10. Select the purpose for the authorization. Initial next to the first line if purpose is for evaluation, treatment planning, service coordination, monitoring, and treatment referral or, initial the line next to "Other" and write in the purpose if it is different from what is listed above. Some examples are legal, benefits, employment, etc.
11. Read the client authorization section.
12. Select the expiration date for the authorization by initialing one of the following:
    Annually (expires one year from signature date) or,
    Time-Limited (expires 30 days from signature date) or,
    Fill in an alternate date or event (not to exceed one year from signature date).
13. Sign (and date) this line if you are the client acting on your own behalf (age 13 and above).
14. If signing on behalf of the client, initial the line that corresponds with your authority to sign the authorization.
15. Signature of Authority (Parent of Minor, Guardian, Power of Attorney, Other Authorized Representative).

    Date of Signature of Authority.

    Legal documentation proving authority (such as Guardianship, Durable Power of Attorney, etc.) may be required in order to sign on client's behalf.
16. If signing as Authority or Witness, print first and last name.
17. Signature of Witness required if client signs by mark (instead of signing name).

    Date of Signature of Witness.
18. Staff person receiving authorization from the client and forwarding it to the Records department will review for completeness, provide explanation and assistance as needed, **print first and last name**, and fill in client ID number.