

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

Authorization to Release-Obtain Information

2 Intity Name (if applicable): NA 4 Entity Department (if Entity Name is listed): NA 5 Address: City/State/Zip Code: Phone: 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/STE of the ordination initialed below to be RELEASED to the person/entity named above: Diagnostic Information initialed below to be RELEASED to the person/entity named above: Diagnostic Information Psychiatric Evaluations Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Labs/Univer Drug Screens/Test Results Appointment/Altendance Diagnostic Information initialed below to be DETAINED from the person/entity named above: Diagnostic Information Psychiatric Evaluations Service/Treatment Plans Medical Progress Notes Discharge Summaries Medical Progress Notes Substance Use Assessments Medical Progress Notes Substance Use Assessments Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Discharge Summaries Medical Progress Notes Discharge Summaries Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Progress Notes Other: Labs/Universory Summaries Progress Notes Discharge Summaries Medical Information of the Medical Inform	1 Client Name: I authorize Bridges Behavioral Hea individual/entity:	lth OMBUDS to exchan	ge information (as indicated in s	_ Date of Birth: sections 6-10) with the following
3 Entity Name (if applicable):	2 Individual:		Relatio	nship:
4 Entity Department (if Entity Name is listed): NA 5 Address: City/State/Zip Code:				·
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/STI 7 I authorize the information initialed below to be RELEASED to the person/entity named above: Diagnostic Information Intake Assessments Medical Progress Notes Discharge Summaries Service/Treatment Plans Progress Notes Progress Notes Progress Notes Progress Notes Progress Notes Progress Notes Diagnostic Information initialed below to be OBTAINED from the person/entity named above: Diagnostic Information Psychiatric Evaluations Intake Assessments Intake Assessments Intake Assessments Discharge Summaries Medical Progress Notes Substance Use Assessments Intake Assessments Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Assessments Intake Assessments Intake Assessments Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Other: IEP (Individualized Education Plany) I authorize (initial one): ALL EPISODES OF CARE (OR) Service Dates from: Intrough: 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 signatus is REGUIRED in order to release information in order to release information concerning that minor's sensually, including but not limited to inclination in the information in the information in the information in the information i	, , , ,			
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/STI 7 I authorize the information initialed below to be RELEASED to the person/entity named above: Diagnostic Information Intake Assessments Medical Progress Notes Discharge Summaries Service/Treatment Plans Progress Notes Progress Notes Progress Notes Progress Notes Progress Notes Progress Notes Diagnostic Information initialed below to be OBTAINED from the person/entity named above: Diagnostic Information Psychiatric Evaluations Intake Assessments Intake Assessments Intake Assessments Discharge Summaries Medical Progress Notes Substance Use Assessments Intake Assessments Discharge Summaries Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Assessments Intake Assessments Intake Assessments Medical Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Substance Use Tx Authorizations Service/Treatment Plans Progress Notes Other: IEP (Individualized Education Plany) I authorize (initial one): ALL EPISODES OF CARE (OR) Service Dates from: Intrough: 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 signatus is REGUIRED in order to release information in order to release information concerning that minor's sensually, including but not limited to inclination in the information in the information in the information in the information i	5 Address:	·		
Phone:				
of the following type(s) of healthcare information: MENTAL HEALTH SUBSTANCE USEHIV/AIDS/STC				
Diagnostic Information	6 By initialing on the corresponding	g line, I authorize Ombu	ids to release/obtain information	
Diagnostic Information	Diagnostic Information Intake Assessments Discharge Summaries Service/Treatment Plans	Psychiatric Ev Medical Progre Medications/Pi Labs/Urine Dru	aluations ess Notes rescriptions ug Screens/Test Results	Substance Use Assessments Substance Use Tx Authorizations Substance Use Monthly Reports Appointment/Attendance
Purpose of disclosure (initial one):	Diagnostic Information Intake Assessments Discharge Summaries Service/Treatment Plans	Psychiatric Ev Medical Progre Medications/P Labs/Urine Dru	aluations ess Notes rescriptions ug Screens/Test Results	Substance Use Assessments Substance Use Tx Authorizations Substance Use Monthly Reports Appointment/Attendance
I authorize OMBUDS to use/exchange my health information noted above for the purpose of evaluation, treatment planning service coordination, monitoring, and treatment referral. Other (list purpose): To have the Ombuds represent me through the grievance process. 11 Lunderstand 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 sexuality, including but not limited to information concerning that minor's signature is REQUIRED in order to release information regarding that minor's sexuality, including but not limited to information concerning HIV/AID contraception, pregnancy and/or termination of a pregnancy, sterilization, and sexuality transmitted diseases if that minor has reached his or her fourteenth birthda Lunderstand that the person that receives confidential information may not further disclose such information in the information concerns drug or alcohol use treatment. However, I also understand that the person that receives other types of confidential information if the information concerns drug or alcohol use treatment. However, I also 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 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 understant 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)TIME-LIMITED (Expires 30 days from signature date (OR)TIME-LIMITED (Expires 30 days from signature date (OR)	9 I authorize (initial one):A	LL EPISODES OF CAR	RE (OR)Service Dates	from:through:
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 birthds. A minor's signature is REQUIRED in order to release information regarding that minor's sexuality, including but not limited to information concerning HIV/AID contraception, pregnancy and/or termination of a pregnancy, sterilization, and sexuality transmitted diseases if that minor has reached his or her fourteenth birthds understand that the person that receives confidential information may not further discloses such information in the information concerns drug or alcohol use treatment. However, I also understand that the person that receives other types of confidential information may have the ability to disclose the information 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 information. 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 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 understant 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)TIME-LIMITED (Expires 30 days from signature date)	10 Purpose of disclosure (initial or	<mark>ne</mark>):		
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 birthdat A minor's signature is REQUIRED in order to release information regarding that minor's sexuality including but not limited to information concerning HIV/AID contraception, pregnancy and/or termination of a pregnancy, sterilization, and sexually transmitted diseases if that minor has reached his or her fourteenth birthdat I understand that the person that receives confidential information may not further disclose such information if the information concerns drug or alcohol use treatment. However, I also understand that the person that receives other types of confidential information may have the ability to disclose the information 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 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 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 understant 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)TIME-LIMITED (Expires 30 days from signature date (OR)TIME-LIMITED (Expires 30 days from signature date (OR)	service coordination, n	monitoring, and treatmer	nt referral.	
(OR)ALTERNATE DATE or EVENT requested by client: **All authorizations will automatically expire 30 days after discharge from services** 13 Signature of Client: Date: Parent of Minor Guardian Power of Attorney Other Authorized Representative 15 Signature of Authority: Date: Date: Date:	11 I understand that information used/di is REQUIRED in order to release informat A minor's signature is REQUIRED in order contraception, pregnancy and/or terminati I understand that the person that receive treatment. However, I also understand allowed by relevant state law and federa confidential. I further understand the understand that I will not be denied service.	isclosed under this authorization concerning that minor's der to release information retion of a pregnancy, sterilization confidential information in that the person that receive al regulations. In that case, at I may revoke this consent the if I refuse to sign a release	tion may be disclosed verbally, electron mental health or drug/alcohol treatme garding that minor's sexuality, includ- ion, and sexually transmitted diseases may not further disclose such informates are so ther types of confidential informates and to the extent that such re-disclorate at any time except to the extent that	onically, or by hard copy or facsimile. A minor's signature in tif that minor has reached his or her thirteenth birthdating but not limited to information concerning HIV/AID is if that minor has reached his or her fourteenth birthdation if the information concerns drug or alcohol use tion may have the ability to disclose the information absure may take place, this information will no longer baction has already been taken in reliance on it. Finally
All authorizations will automatically expire 30 days after discharge from services 13 Signature of Client:	12 (Initial one):ANNUALLY	(Expires 1 year from sig	nature date) (OR)TIME	E-LIMITED (Expires 30 days from signature date
13 Signature of Client:	(OR)ALTERNAT	E DATE or EVENT requ	uested by client:	
14 If signing below on behalf of client, please initial the basis for your authority. Documentation proving authority may be required. Parent of MinorGuardianPower of AttorneyOther Authorized Representative 15 Signature of Authority:	**All auti	horizations will automat	tically expire 30 days after disci	harge from services**
Parent of MinorGuardianPower of AttorneyOther Authorized Representative 15 Signature of Authority: Date:	13 Signature of Client:			Date:
16 Printed Name of Authority (or Witness if signatory below): 17 Signature of Witness (if client signs by mark): Date:		•	•	
17 Signature of Witness (if client signs by mark): Date:	15 Signature of Authority:			Date:
	16 Printed Name of Authority (d	or Witness if signatory	below):	
18 Staff Receiving Authorization (Printed): Client ID:	17 Signature of Witness (if clien	nt signs by mark):		Date:
	18 Staff Receiving Authorizat	t ion (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 <u>or</u>, 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.