AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR PAYMENT AND REIMBURSEMENT PURPOSES

Client Information *Please print legibly.*	Name*_____ Date of Birth*_____ Other Names Used:_____ Phone Number:_____ *Parent/Guardian/Legal Representative Name (where applicable)*_____
Insurance Company Information/TPA *With **whom** may Trauma Informed Therapies (TIT) share your information?*	_____ Name of Insurance Company/Third Party Administrator* _____ _____ Phone Number Fax Number _____ Address (street, city, state, zip code) **Required Field*
Communication ***How** will TIT share your information?*	I authorize Trauma Informed Therapies to exchange the information indicated below by verbal communication, or by sending and requesting paper copes via US mail or fax.
Information to be Released ***What** is to be released?*	I authorize Trauma Informed Therapies to release ALL information pertaining my treatment, including but not limited to: Intake Evaluations/Diagnostic Assessment Individual Therapy Notes/Progress Notes Nutritional, Medical, and Psychiatric Documentation Genetic Information Treatment Plans/Discharge Summaries Treatment Plans/Discharge Summaries Substance Use Disorder Records Administrative Records (e.g. appointment listings, billing) HIV/AIDS Records __Other (please specify)_____
Purpose of the Release of Information ***Why** is the release needed?*	I understand the purpose of this release is to file, process, and support insurance claim(s), obtain authorization, communicate information needed to substantiate the claim, and participate in the review process to determine medical necessity for my level of care and continued treatment.

Statement of Authorization:

I understand that:

- I may revoke this consent at any time, except to the extent that Trauma Informed Therapies (TIT) has already acted in reliance on it, by providing oral or written notice to TIT at the address noted in the Notice of Privacy Practices. If I revoke this authorization, I will be responsible for payment in full of all my treatment costs to the extent they are not otherwise paid on my behalf. **This consent automatically expires three (3) years after my last date of service at TIT.**
- I have been informed what information will be released, its purpose, and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in TIT's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires TIT to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. TIT will not condition treatment based on whether I sign this authorization. I understand that if I refuse to sign this authorization, I am electing to self-pay for services at TIT as specified in the Financial Policy Agreement.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE TRAUMA INFORMED THERAPIES TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.

_____

Client Signature* Parent/Guardian/Representative Signature **Date**

Age of consent for **mental health records is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent.*

***Age of consent for **substance abuse records** is 12 for outpatient, 18 for residential in the state of Washington*

Legal Representative *(where applicable)*: I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

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Legal Guardian/Representative Signature Relationship to Client/Legal Authority **Date**

Effective: 7/25/2018