RELEASE OF INFORMATION FORM: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Information *Please print legibly.*	Name*_____ Date of Birth*_____ Other Names Used: _____ Phone Number:_____ *Parent/Guardian/Legal Representative Name (where applicable)*_____
Health Care Provider, Person, Agency, or Emergency Contact *With whom may Trauma Informed Therapies (TIT) share/receive your information?*	_____ Clinic/Physician/Provider, Insurer, Person, Agency* (e.g. Dr. John Smith, Children's Hospital) _____ _____ Relationship to Client* Phone Number* _____ _____ Address (street, city, state, zip code)* Fax Number **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 copies via US mail or fax. **OR** __ONLY verbally communicating the information as needed for purposes identified below.
Information to be Released *What is to be released?*	__All Records (including **all** items listed below) __Intake Evaluations/Diagnostic Assessment __Individual Therapy Notes/Progress Notes __Nutritional, Medical, and Psychiatric Documentation __Treatment Plans/Discharge Summaries __Genetic Information __Psychiatric Documentation __HIV/AIDS Records __Substance Use Disorder Records __Administrative Records (e.g. appointment listings, billing) __Medical Documentation/Labs __Other (please specify)_____
Purpose of the Release of Information *Why is the release needed?*	__Coordination of Care __Discharge and Continuation of Care __Client Request __Insurance __Litigation/Legal Purposes __Other (please specify)_____

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. **After one year, this consent automatically expires.**
- 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, payment, enrollment, or eligibility for services based on whether I sign this authorization.

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.

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

Age of Consent for **mental health records is 13 in the state of Washington*
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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Parent/Legal Guardian/Representative Signature Relationship to Client/Legal Authority **Date**

Effective: 7/25/2018