THE SUQUAMISH TRIBE
WELLNESS CENTER
PO Box 1228
Suquamish, WA 98392
PHONE 360-394-8558 FAX 360-598-1724

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, Date of Birth_____
hereby authorize release of confidential information about my behavioral health record, including my mental health, substance use disorder and/or psychiatry services, as relevant:

☐ A mutual exchange of information between The Suquamish Tribe's Wellness Center and the entity or provider named below
☐ The entity of provider named below request information from The Suquamish Tribe's Wellness Center
☐ The Suquamish Tribe's Wellness Center requests information from the agency or provider named below

Provider/Entity/Agency name and address: _____

Phone: _____ Fax: _____

The following information: ☐ **Assessment Results (including diagnosis and recommendations),** ☐ **Full Assessment Packet (TARGET, ASAM)** ☐ **Clinical Impressions,** ☐ **Status Reports,** ☐ **Program Attendance,** ☐ **UA and other lab reports,** ☐ **Discharge Summary (including transfer and/or aftercare recommendations),** ☐ **Other:** _____

The purpose of the disclosure authorized herein is to: ☐ **Coordinate services,** ☐ **Monitor compliance with treatment recommendations,** ☐ **Comply with court order,** ☐ **Other**_____

I understand that my records are protected under Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR, Part 2, The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 & 164, and Washington State confidentiality laws, where applicable. These records cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event**, this consent expires**

☐ Automatically within 30 days following conclusion of services at Wellness,
☐ 1 year from date of signature unless state and/or federal law and regulations expressly state otherwise,
☐ At completion/termination of legal supervision from referring party,
☐ Specific Date:_____

The information will be released in the following form(s):
☐ Written ☐ Verbal ☐ Audio ☐ Video ☐ Electronic, including fax & secure email ☐ Other_____

I understand that generally this agency may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Participant Signature Date

_____ _____
Wellness Staff Signature Date

Notice of Redisclosure of Confidential Information: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2, and 45 CFR Part 164. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Part 164.