THE SUQUAMISH TRIBE
HEALTH DIVISION

PO Box 1228
Suquamish, WA 98392

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, Date of Birth_____
hereby authorize release of confidential information about my health record, including my primary health care, mental health, substance use disorder and/or psychiatry services, as relevant. I permit communication between the parties below in the manner indicated below:

☐ To ☐ From_____The Suquamish Tribe Wellness Center **Phone**: (360) 394-8558 **Fax:** (360) 598-1724

☐ To ☐ From_____The Suquamish Tribe Medical Clinic **Phone: (360) 394-1350 Fax:** (360) 598-2783

☐ To ☐ From_____Suquamish Tribe Community Health **Phone:** (360) 394-8469 **Fax: (360) 598-2783**

☐ To ☐ From_____**Phone:**_____**Fax:**_____

The following information: ☐ Assessment Results including diagnosis and recommendations, ☐ Clinical Impressions, ☐ Status Reports, ☐ Program Attendance, ☐ Lab Reports ☐ Urinalysis, ☐ Radiology/Imaging☐ Discharge Summary (including transfer and/or aftercare recommendations),
☐Other: _____

☐Please provide health record for the individual in the time frame: to 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.

_____ _____
Patient Signature (Parent/Guardian if patient is under age 13) Date

_____ _____
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.