ASPIRE BEHVIORAL HEALTH COUNSELING SERVICES, CO.

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Consumer Name: ________________________ Date of Birth: ______________

With my signature below, I authorize ____ and ABHCS to

☐ **OBTAIN** health care information **FROM** ☐ **DISCLOSE** health care information **TO**:

Contact Person: ____________________________ Organization: __________________________

Address: ________________________________ Telephone: ___________________________

City, State, Zip: ____________________________ Fax: ________________________________

Please **check** information to be used/disclosed consists of mental healthcare information, including:

☐ Assessment or Evaluation ☐ Treatment Plan ☐ Notes
☐ Coordination of Care ☐ Consultation ☐ Financial
☐ Other: ____________________ ☐ School Performance/IEP ☐ Discharge Plan

The purpose for the disclosure/communication:

☐ Coordination of Care ☐ Other: ____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I **place my INITIALS** in the applicable area.

_____ Mental health information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ HIV/AIDS testing or testing of any sexually transmitted disease
_____ Genetic testing information

Other information:
I understand that my records are protected under federal and state confidentiality regulation, including HIPAA, CFR 42, Part 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I understand Aspire cannot guarantee that the recipient will re-disclose my health information to a third party. The recipient is prohibited under federal law from making further disclosure of such information unless further consent from me has been obtained, unless otherwise permitted under 42 CFR, 2 & 8.

I understand that I may revoke this consent in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. I understand this consent is subject to revocation at any time except action has been taken in reliance.

I have read and understand that the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.
Unless revoked, this authorization expires 60 days after the completion of treatment or: ______________________________

Client Signature: ____ Date ______________

Parent/Guardian/Representative Signature ____________________________ Date ______________

If personal representative, print name: ______________________________
Relationship to client: ☐ Parent ☐ Legal guardian ☐ Power of Attorney/Healthcare ☐ Other