YAKAMA NATION BEHAVIORAL HEALTH PROGRAM
AUTHORIZATION TO DISCLOSE

**** Authorization for Use of Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. (Parts 160 and 164).**

Authorization

I authorize_____ (mental health care provider) to use and/or disclose the protected health information described below to:

_____

Individual/Agency **Specify Person (if known)**

_____

Street Address ***City/State/Zip*** ***Telephone***

I authorize the release of my medical health record/s to include (check items):

☐Intake Assessment	☐Discharge Summary	Method:
☐Treatment Plan	☐Pertinent Medical or	☐Read ☐Verbal
☐Progress Notes	Mental Health Records	☐Provide copies
☐Psychological/Psychiatric Evaluation	☐Adoption or Foster Care Records	Date Range:_____

☐Other (Specify)_____

For the Purpose of_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.

_____
(Initials)

I Understand:

- That my records are protected under Federal and Washington State Law and cannot be disclosed for purposes other than treatment, payment, and operations without my written authorization unless otherwise provided for in regulations.
- My records maybe used for health and oversight activities to assess program performance for CQI purposes.
- That my written authorization is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.
- That the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected.
- That I will be given a copy of this signed authorization and have the right to inspect or copy the information to be used or disclosed.
- That I have the right to refuse to sign the authorization and that YNBHS will not condition treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of authorization.
- That YNBHS reserves the right to charge a reasonable fee for provision of records.
- That I may revoke this authorization at any time by checking the Revoked box, dating, and initialing it.

If the client is less than 13 years old, this release must be signed by parent/guardian. This authorization shall be in force and effect until_____ or after 90 days unless updated. This form must be signed after it has been completely filled out.

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian **Description of Authority** **Date**

☐Copy given to client: Initials_____ ☐Copy refused by client: Initials_____ ☐Revoked Date:_____ Initials_____