



◆ 2400 NE 95TH STREET ◆ SEATTLE, WA 98115-2499 ◆ (206) 525-5050 ◆ Fax (206) 525-9795

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

(42 CFR, Part 2, § 2.14; RCW 71.05.620; RCW 70.02.030)

Name of Client/Patient: _____			ID # _____
Last	First	Middle	D.O.B. _____

<input type="checkbox"/> I authorize Ryther to disclose to:	<input type="checkbox"/> I authorize the following person/agency to disclose to Ryther: _____
Person (name): _____	Relation to client: _____
Facility: _____	Address: _____
Phone no.: _____	Fax no.: _____

**ITEMS AUTHORIZED FOR RELEASE:** Please check box(es).

<input type="checkbox"/> Assessment/ Assmt. Summary	<input type="checkbox"/> Treatment Plans/Progress	<input type="checkbox"/> Developmental History
<input type="checkbox"/> Referrals/Recommendations	<input type="checkbox"/> Admission Summary	<input type="checkbox"/> Medical Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physical/T.B. Test Results	<input type="checkbox"/> Educ./Emp./Voc. History
<input type="checkbox"/> Presence in Facility	<input type="checkbox"/> Psych. Evaluations & History	
<input type="checkbox"/> Benefits information	<input type="checkbox"/> Other: _____	

**THIS CONSENT ALLOWS THE RELEASE OF INFORMATION PERTAINING TO:**

**[Write your initials next to each selected item (checked box) that you authorize for disclosure.]**

___ <input type="checkbox"/> chemical dependency diagnosis and treatment	___ <input type="checkbox"/> STD test results/treatment
___ <input type="checkbox"/> mental health diagnosis and treatment	___ <input type="checkbox"/> HIV (AIDS) testing/treatment

**PURPOSE OF DISCLOSURE OF INFORMATION:**

<input type="checkbox"/> to provide for client's current needs	<input type="checkbox"/> to help meet client's educational/employment/vocational goals
<input type="checkbox"/> legal matter: probation and monitoring	<input type="checkbox"/> continuum of care
<input type="checkbox"/> billing	<input type="checkbox"/> other: _____

**MEANS OF RELEASE** (Copies or facsimiles of this consent form are as valid as the original):

<input type="checkbox"/> Verbal	<input type="checkbox"/> Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Telephone	<input type="checkbox"/> Email	<input type="checkbox"/> Hand-Carried
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**NAME OF RCC STAFF WHO WILL RELEASE INFO:** \_\_\_\_\_

**SIGNATURE REQUIREMENTS:**

<b>Minor Client age 13-17:</b> signature required to release chemical dependency or mental health information or if signature was required to obtain treatment. (42 CFR, Part 2; WAC 275-57-350)	<b>Guardian:</b> signature required if signature was required to obtain treatment.. (42 CFR, Part 2; WAC 275-57-350)
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I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the 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 (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below.

**EXPIRATION:** Unless earlier revoked in writing, this consent shall expire: in 90 days from the signature date for a one time release of information, or; 1 year from the signature date to facilitate case coordination with external parties. Release to third-party payers exempt from 30-day limit per RCW 70.02.030; consent valid until financial closure of case

**AUTHORIZATION:** I understand Ryther will not condition the provision of treatment, payment, enrollment, or eligibility for benefits on the provision of an authorization 42CFR Sec164.508

Month/Day/ Year \_\_\_\_\_

Signature of Client \_\_\_\_\_

Signature of Guardian \_\_\_\_\_

Initials of Authorized Staff \_\_\_\_\_

I further acknowledge that the information to be released was fully explained to me, and this consent is given of my own free will.

**DRUG AND ALCOHOL USE INFORMATION PROHIBITION ON REDISCLOSURE:** The federal rules (42 CFR, Part 2) prohibit you from making any further disclosure of 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. A general authorization for the release of information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**CLIENT/GUARDIAN INITIALS:** \_\_\_\_\_ I have received a copy of this completed consent form on date of my signing.