Quinault Wellness Center

511 W. Heron Street, Aberdeen WA 98520
Phone: (564)544-1950 Fax: (564)544-1928

AUTHORIZATION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

Name of Patient: _____ DOB: _____

I authorize the Quinault Wellness Center to receive and disclose written and/or verbal information pertaining to the following (patient to initial):

_____ All of my Substance Use Disorder Records
(May include any/all items below)

_____ All of my Mental Health Counseling Records
(May include any/all items below)

_____ All of my Dental Records
(May include any/all items below)

_____ All of my Medical Records and medications, including Substance Use Disorder information
(May include any/all items below)

OR limited to the following specified information (patient to initial)

_____ The fact that I am a patient at the clinic

_____ Bio/Psycho/Social-substance use disorder/gambling assessments and evaluations

_____ Bio/Psycho/Social- mental health/psychiatric/psychological assessments and evaluations

_____ Medical exams, evaluations, and all of my medications, including substance use disorder medications

_____ All of my lab tests, including results relating to substance use disorder. Example: drug screen urinalysis

_____ Substance use disorder treatment compliance

_____ Mental health counseling treatment compliance

_____ Discharge summary including substance use disorder/mental health information

_____ Intra-Oral (IO) photos, Cone beam computer tomography (CBCT/3D imaging), dental x-rays

_____ Other (specify): _____

This information initialed above should be released by/received by:

Individual and/or Agency: Grays Harbor County Superior Court: Therapeutic Court Programs

Address: 219 E. Pioneer Avenue, Montesano, WA 98536

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse consent to a disclosure for other purposes. **Describe the specific purpose of the disclosure for information to be released:**

My participation in the Grays Harbor Superior Court, Therapeutic Court Program.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

The sooner of the following: upon completion of my Therapeutic Court Contract or 90 Days Post Discharge from Treatment

[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

Patient Signature: _____ Authorization Date: _____
(13 years and older)

Witness: _____

Date revoked: _____ Staff initials _____