Washington State Health Care Authority

Request for Courtesy Dosing

Please fill out completely and legibly

Please include signed ROI and state photo ID

Home Clinic Information			
TODAY"S DATE Click or tap to enter a date.	Name of home OTP		
Address	City,	State	Zip
OTP main phone number/Fax	OTP dispensary direct phone number	OTP Dispensary direct Fax number	

TO (or, Receiving Clinic)			
Name of Receiving Clinic			
Address	City,	State	Zip
OTP main phone number/Fax	OTP dispensary direct phone number	OTP Dispensary direct Fax number	
Dose Verified By	Title		

Patient Demographics			
Patient Clinic ID Number	First name	Last name	Middle Initial
Date of Birth	Social Security number	Gender: ☐ Female ☐ Male ☐ Other	If Female, pregnant? ☐ Yes ☐ No

Reason for Courtesy Dosing (i.e. vacation, work, request for permanent transfer, etc.):

Any relevant medical conditions/medications

Is patient on daily or random breathalyzer testing? ☐ Yes ☐ No Frequency

Dosing Information	
Dispensing **START DATE** Click or tap to enter a date.	Dispensing **END DATE** Click or tap to enter a date.
Choose one Methadone Dosage	Take-Home Doses Authorized? ☐ Yes ☐ No Dosing Schedule
Special Instructions (i.e. other observed medications, split dosing, etc.)	
Patient is informed of all fees and dosing hours ☐ Yes ☐ No Patient Primary Insurance Choose one Medicaid *If receiving clinic is contracted with Medicaid, no fees are to be collected from Medicaid patients.*	Pt. Diagnosis code
Staff person making transfer request (print name)]	Medical Director or SAMHSA-approved prescribing delegate
Medical Order Written Click or tap to enter a date.	

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 _____