Release of Information

❶ **Name:**_______________________________________ **FBH ID:** ______________________

Phone: _______________________________________ **Date of Birth:** __________________

Frontier Behavioral Health (FBH) 107 S. Division St. Spokane, WA 99202 Phone: (509) 838-4651 Fax: (509) 456-4536 Alt. Fax: (509) 458-7449	❷ Entity/Individual:____________________________ Relationship:______________________________ Address:__________________________________ City:_____________________________________ State:______________ ZIP:__________________ Phone: ___________________________________ Fax:_____________________________________	❸ ***Initial*** *only one item* _______Mutual disclosure between FBH and the name of individual/entity listed. _______FBH may disclose to individual/entity listed. _______Individual/entity listed may disclose to FBH.

❹ **Purpose:**____ **Date Range**:_______________to ___________

Default information is 1 year and/or most recent episode of care whichever is shorter.

❺ **Information to INCLUDE**: *(Please **initial** all applicable items. If you are authorizing the disclosure of your entire record, please **initial** all items below.)*

_______Progress/Chart Notes

_______Assessment/Evaluation

_______Treatment/Care Plan

_______Psychiatric/Medical Orders & Notes

_______Collateral/3rd Party Information

_______Court/Legal documents

_______Discharge Summaries

_______Referral/Care Coordination

_______Alcohol/Substance Use Assessment, Placement, or Treatment information *(required initial if bound by 42 CFR Part 2)*

_______HIV/AIDS and/or Sexually Transmitted Diseases

_______Other Behavioral Health/FBH Program Information *(please specify)*: ________________________________

_______For the purpose of limiting this authorizing for verbal communication/coordination or emergency contact only, I authorize the disclosure of all information **with the exception of Alcohol/Substance Use or Treatment unless specified above.**

❻ **Information to EXCLUDE** *(please specify)*:____

❼ **Expiration:** ☐60 Days after discharge from FBH ☐Date:________________ ☐Event: ______________________

❽ *Health information is protected under federal regulations governing confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, as well as subsets under state RCW 70.02, RCW 71.05, RCW 71.34, WAC 388-865 and WAC 388-877. If the disclosing party is required to comply with 42 CFR Part 2 regulations, as is FBH, then there are additional protections for my alcohol and drug use information and treatment in my health record. In addition, those health information records cannot be disclosed without my written consent unless otherwise provided for in the regulation. FBH cannot guarantee that the Recipient of my information will not re-disclose my health information to a third party since the Recipient may not be subject to 42 CFR Part 2 regulations. If the disclosure consists of treatment information about me as a person enrolled in a federally-assisted substance use disorder program, the Recipient is prohibited under federal law from re-disclosing such information unless I provide written consent for further disclosure or as permitted under 42 CFR Part 2. To help protect your privacy, FBH includes a notice to the recipient indicating that they are prohibited from re-disclosing certain health care information unless there is written consent from you to do so. I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I have read and understand the terms of this Authorization and I am entitled to a copy of this Authorization after I sign it. I may refuse to sign this Authorization, and my refusal to sign this Authorization will not affect my ability to receive treatment at FBH. Method of transmitting or sharing information may include face-to-face, fax, mail, phone, written and electronically.*

❾ **Signature:**____ **Date:** _____________

If the individual is twelve (12) years of age or younger, or the adult is a dependent; a parent, legal guardian or other representative is required to sign below.

❿ **Legal Guardian's signature (if required):**______________________________ **Date:** _____________

⓫ **Print Name:**____________________________________ **Relationship:** ______________________

FBH USE ONLY: Staff Name:________________________________ Date: ___________________

Medical Records Instructions: ☐ Release Records ☐ Request Records ☐ Scan/File Only