**YAKAMA NATION BEHAVIORAL HEALTH SERVICES**

**511 South Elm Street Phone: (509)865-5121 Ext.7633**

**Toppenish, WA 98948 Fax: (509)865-2266**

**Authorization to Release of Information**

Authorization for Use of Disclosure of Protected Health Information (PHI, Required by the Health Insurance Portability and Accountability Act, 45 C.F.R (Part 160 and 164)). Substance use disorder records are protected under the Federal regulations governing Confidentiality and 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. pts 160 & 164.

I, request and authorize YAKAMA NATION BEHAVIORAL HEALTH SERVICES to release the healthcare information for client: DOB: to:

Person / Agency:

Address:

This request and authorization applies to (check all that apply):

Intake Assessment

Treatment Plan

Progress Notes

Discharge Summary

Pertinent Medical, Mental or Behavioral Health Records

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Understand:**

* That my records (including substance use disorder 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.
* 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 the provision of records.
* 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 at program completion or discharge.

Client Signature Date

**If client is younger than 13 years old:**

Name of Parent / legal guardian Description of Authority

Parent/Legal Guardian Signature Date

**Copy given/mailed by: Date:**