



Authorization to Release or Request Information (ROI)

Client Name: _____ MRN: _____ DOB: _____

Release Date: _____

Authorization Type:

- Release To
- Request From
- Mutual Exchange (Verbal)
- Mutual Exchange (Records)

Expiration

- Date of Discharge from Sound
- Upon One-Time Release of Information
- Specific Date: _____

Sound Health

Address: 6400 Southcenter Blvd
City / State / Zip: Tukwila, WA 98188
Phone: 206.901.2000
Fax: 206.302.2210

Attn: Health Information Management
Email: RecordsStaffOnly@Sound.Health

Name / Role: _____

Organization Name (if applicable): _____

Address: _____

City / State / Zip: _____

Phone: _____ **Fax:** _____ **Email:** _____

I authorize release of the following medical, mental health and/or substance use disorder information,

Types of Records

- Minimum necessary to verbally coordinate care
- All SUD Tx
- All OT Tx
- All MH Tx
- All Medical Tx
- Other as indicated below

Records to be Disclosed or Requested: (check all that apply)

- MH Standard Set *
- Crisis Plan
- Scheduling/Appointment History
- Substance Use Disorder Summaries
- Care Management/Community Support
- Medication Assisted Treatment Notes
- Full Diagnoses List (includes SUD)
- Individual and Family Treatment
- Progress Reports for Court/Probation
- Assessment(s), Update(s)
- Treatment Plan(s)
- Discharge Summary
- Medical Initial and Follow-up Notes
- SUD Standard Set**
- Active Medications
- Laboratory Reports/Results
- Group Treatment
- Other

*MH Assessment, Psych Evaluation, Treatment Plan, Diagnosis, MH Medical Notes, Medication List, Discharge Summary (if applicable)

** SUD Assessment Summary, Treatment Plan, Diagnosis, Discharge Summary (if applicable)

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If Other, specify records

I understand that:

Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of record. (RCW 70.02.10 and RCW71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 7.70.068). Any records that contain information regarding mental health are protected by state law (RCW 70.02); HIV/AIDS or confirmed STD tests or treatment records are protected by state confidentiality laws (RCW 70.24). 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 may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Substance Use Disorder Program information, I may do this verbally to SUD clinical staff or program manager; or in writing. I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by Federal Privacy Standards.

Signature

Relationship to Client

Date