TACID
Promoting the Independence of individuals with disabilities

Behavioral Health Ombuds for Pierce County

6315 South19th Street
Tacoma, WA 98466
Phone: 253.302.5311 Toll Free: 800.531.0508 Fax: 253.565.5578

Authorization of Information and Record Exchange

I, _____ Date of Birth: _____
(Print Legal Name)

hereby authorize Behavioral Health Ombuds for Pierce County and the following entity(ies) to mutually disclose the specified information in writing or verbally for the service received from _____ to _____
date **date**

Initial	Name / Agency / MCO / BH-ASO	City, State	Phone	Fax

Please initial the information to be disclosed:

_____ Discharge Summary
_____ Other information pertinent to the grievance
_____ Behavioral Health Evaluations and progress notes
_____ Treatment Plan
_____ Other: _____
_____ Inventory Sheet
_____ Medication Treatment Plan
_____ Crisis service report
_____ Face Sheet

Purpose and need for disclosure:

_____ Resolving the complaint or grievance I have asked the Ombuds to investigate
_____ Other (Specify) _____

I understand and agree to the release of information authorized in this form. **This authorization shall remain in force for a period of ninety (90) days from the date it is signed.** I understand that my express written permission is required to release any health care information related to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug and/or alcohol use

I understand I may revoke this release verbally or in writing at any time, but that revocation will not affect any information that was already released.

Date of revocation		Method of revocation		
		Written		Verbal

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996(HIPAA), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I do not have to sign this authorization in order to obtain health care benefits, treatment, payment or enrollment.

Consumer Legal Name	Consumer Signature	Date

If the consumer is under 13 years of age, or is an adult with a court appointed guardian, the consumer's parent or guardian must sign this release.

Parent or Guardian Name	Parent or Guardian Signature	Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.