AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE SW WA YOUTH NAVIGATOR MULTIDISCIPLINARY TEAM

Name_____ Date of Birth_____

By signing below, I authorize the SW WA Youth Navigator Multidisciplinary Team, which includes staff from the following entities:

Carelon	Molina Health Care	Department of Child, Youth and Families	Family Behavioral Health	Real Life Counseling
Child and Adolescent Clinic	Skyline Hospital	Klickitat County DCR	Community Health Plan of Washington	Boys and Girls Club
Kids Mental Health WA	Klickitat Valley Health	Klickitat County Juvenile Court	Teen Talk	Dad's Move
Clark County Juvenile Court	Culture Seed	Educational School District 105	Educational School District 112	Developmental Disabilities Administration
Wellpoint	Coordinated Care	Vancouver Police Department	Legacy Health ER	Peace Health ER
Washington Gorge Action Programs	Open House Ministries	Northwest EMDR	Skamania County Juvenile Court	Battle Ground Public Schools
School (please fill in)	Other (fill in any other supports)	Other:	Other:	Other:

To communicate with and disclose to one another the following information *(Please check all appropriate boxes):*

- ☐ Initial and subsequent evaluations of my service needs by the Community Collaboration and its members
- ☐ Current and past Mental Health Treatment Programs, with dates
- ☐ Current and past Substance Use Disorder Treatment Programs, with dates
- ☐ Current and past Emergency Department visits, with dates
- ☐ Past or present Substance Use Disorder Problems or Diagnosis
- ☐ Past or present Physical Health Problems
- ☐ Other: _____

The purpose of the release/disclosure is to coordinate the following treatment activities: ***assessment, referral, medical, substance use disorders, mental health, vocational, shelter or housing services***.

By signing this authorization, I understand the following:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. Any revocation will not take effect if action has already been taken based on the original authorization. Without my express revocation, this authorization will expire in one year from the signature date below.
- The information disclosed and redisclosed may contain information on my current/past: Mental Health, substance or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by, with the exception of, Substance Use Disorder records which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2.
- I understand that this authorization is voluntary and that I may refuse to sign this form. My refusal to sign will not affect the treatment or services I receive from specific providers but will limit the ability of the workgroup members to discuss my needs and to coordinate my care.

Signature (Patient or Person Authorized to give authorization) **Date**

_____

If signed by person other than patient, please print your name, provide reason, relationship to patient, & description of authority

All disclosures and redisclosures must be accompanied by the following notice: "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."