COMMUNITY HEALTH NETWORK of Washington™ | Cascade Select

powered by COMMUNITY HEALTH PLAN of Washington™

# Community Health Network of Washington
# Authorization to Release Confidential Substance Use Disorder Treatment Information

This form is used to release your protected substance use disorder (SUD) treatment (alcohol or drug treatment) information (Part 2 Protected Records) as required by state and federal privacy laws. Your authorization allows Community Health Network of Washington (CHNW) to release your Part 2 Protected Records to person(s) or organization(s) that you specifically name.

**Outpatient SUD treatment:** under Washington law, a minor enrollee must consent to the release of their Part 2 Protected Records for **outpatient** SUD treatment, if they have obtained such treatment without parental consent.

**Inpatient SUD treatment:** under Washington law, a minor 13 years of age or older may receive inpatient SUD treatment without parental consent **only** if the Department of Social and Health Services (DSHS) determines they are a "child in need of services." Any written consent for disclosure of patient identifying information of a minor who has been deemed a "child in need of services" by DSHS may be given **only** by the minor enrollee. On the other hand, any written consent for disclosure of patient identifying information of a minor who has not been deemed a "child in need of services" by DSHS must be given by **both** the minor enrollee and their parent, guardian, or authorized representative.

**1.** **Enrollee Name:** _____ **Date of Birth:** _____

**Enrollee ID Number:** _____ **Date of Request:** _____

**Enrollee Address:** _____

**Enrollee email:** _____

**Enrollee Phone:** _____ **Enrollee Fax:** _____

If parent/guardian consent is for information about inpatient SUD treatment of a minor, please list the minor's name:

_____

**Choose one:** ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

**2.** The above-named enrollee hereby authorizes CHNW to disclose information concerning the enrollee's name and other personal identifying information, their status as a patient obtaining diagnosis, treatment, and referral for treatment with a Part 2 Program, and medications to the below person(s) or organization(s) (attach separate sheet if needed):

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

**3. Check the box(es) below to tell CHNW the specific information you want disclosed (nature and amount of information to be disclosed, as limited as possible):**

☐ All information (claims, appeals, billing, enrollment, etc.).

☐ All benefit claims data related to SUD treatment.

☐ Appeals.

☐ Specific claims (specify date(s) of service, claim number, etc.): _____

☐ Billing/enrollment information.

☐ Records related to my SUD treatment at a Part 2 Program.

☐ Other (please specify): _____

**4.** The purpose of the disclosure herein is to: _____

**5.** I understand that my Part 2 Protected Records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time (verbally or in writing) to the extent that action has been taken in reliance on it, and that **in any event his consent expires automatically as follows** (specify date, event or condition upon which consent expires):

_____

_____ _____ _____

**Enrollee Printed Name** **Enrollee Phone** **Date**

_____

**Enrollee Signature**

**5a.** Signature of parent or guardian for dependent minor enrollee's Part 2 Protected **inpatient** SUD treatment records:

_____ _____ _____

**Parent/Guardian Printed Name** **Parent/Guardian Phone** **Date**

_____

**Parent/Guardian Signature**

☐ Check here if you are signing as a personal representative (person authorized to sign in lieu of enrollee) and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the enrollee signed above.

**Telephone Number of Personal Representative**: _____

**Personal Representative's relationship to the enrollee**: _____

***Give copy of signed form to enrollee and maintain copy in enrollee record.***

**6. Notice prohibiting re-disclosure of patient identifying information:**

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

**7. Send the completed, signed request to:**

Community Health Network of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 652-7050
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHNW's Customer Service department at the following

Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8am to 5pm.

If you hare hearing or speech impaired, please call TTY 711 (toll-free).

The notice is also available online at: https://www.cascadeselect.org/member-center/member-rights/