King County

Mental Health, Chemical Abuse & Dependency Services Division

Consent/Authorization to Release Information

Client Name:	Previous Name:	
Date of Birth:	Social Security Number:	King County ID #:

This is to authorize that the information specified below regarding the above person be disclosed between:

King County Department of Community & Human Services
Mental Health, Chemical Abuse & Dependency Services Division
821 Second Avenue, Suite 610
Seattle, WA 98104
206-205-5308

☐ Cedar Hills Treatment Center

☐ King County Assessment Center

And

Person: _____

Facility/Organization: _____

Address: _____

Phone: _____

Purpose of the disclosure: _____

Specific Information to be disclosed:

- ☐ Current and/or past treatment (specify dates) _____
- ☐ Current and/or past assessments (specify dates) _____
- ☐ Past or present mental health problems or diagnosis
- ☐ Past or present physical health problems
- ☐ Other (specify) _____

My signature below indicates that I understand the following:

- I may revoke this authorization at any time. If I do not, unless I designate a sooner date, this authorization expires in 90 days. A revocation will not effect information already released. (Revocation requests must be made in writing to the Privacy Office at the above address. Revocation request forms are available upon request);
- The information disclosed may contain information about my mental health or past drug or alcohol use;
- The recipient of this information, as specified above, may not be required by federal law to keep the information confidential, and
- If this authorization is to release information for a purpose other than treatment or the payment for my treatment, then I can refuse to sign this form. If I do refuse to sign, a health care entity may not refuse to provide me with treatment, payment, or access to services because of my refusal to sign;
- I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR Part 2 and WAC 388-805) 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 except to the extent that action has been taken in reliance on it. This consent shall expire 90 days form the date signed. I understand that the payment for my treatment, the delivery of my treatment, eligibility for and enrollment in the service program cannot be denied to me based upon my refusal to sign this release of information;
- I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Signature:	
Current Date:	Authorization Expiration Date: