Behavioral Health Ombuds Service

Mutual Authorization for Release of Information

101 N Edison, Box B
Kennewick, WA 99336
509-783-9444
833-783-9444
509-735-1191 (FAX)

Individual's Name: _____

Date of Birth: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I, _____, do hereby authorize Behavioral Health Ombuds Service (BHOS) to exchange and/or discuss information relating to my Complaint, Grievance, Administrative Hearing or HCA Board of Appeals, with:

Provider Agency, Individual, Administrative Service Organization (ASO) or Managed Care Organization (MCO):

Name: _____Telephone #:_____ Fax:_____
Address: _____ City: _____ State: _____ Zip: _____

I ALSO AUTHORIZE BHOS TO REVIEW AND DISCUSS INFORMATION CONTAINED IN MY FILE RELATING TO MY: (Please initial)

- ☐ _____ SUD and/or Mental Health Outpatient treatment during the period of _____; and/or
- ☐ _____ SUD and/or Mental Health Residential treatment during the period of _____.

THE INFORMATION AND DISCUSSION IS REQUESTED FOR THE PURPOSE OF: (Please initial)

- ☐ _____ Resolving the Complaint I have filed and which I have asked Ombuds to investigate.
- ☐ _____ Helping me navigate the Grievance I have filed with my MCO or GCBH-ASO.
- ☐ _____ Helping me navigate the Appeal I have filed with my MCO or GCBH-ASO.
- ☐ _____ Other (Be as specific as possible) _____

SPECIFIC INFORMATION TO BE RELEASED: (Please initial all that apply: _____)

- ☐ _____ Attendance
- ☐ _____ U.A. results
- ☐ _____ Complete copy of intake / assessment
- ☐ _____ Service plans
- ☐ _____ Discharge Summary
- ☐ _____ Psychiatric evaluations / prog notes
- ☐ _____ Other information pertinent to the complaint
- ☐ _____ Progress notes

I understand and agree to the release of information authorized in this form. **This consent is valid for ninety (90) days from the date it was signed**. I understand I may revoke the release in writing at any time, but I understand that revocation will not affect any information that was already released. 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, and HIV (AIDS virus), sexually transmitted diseases. If I have been tested, diagnosed, or treated for psychiatric disorders/mental health, drug and/or alcohol use, HIV (AIDS virus), and sexually transmitted diseases, you are specifically authorized to release all health care information indicated above relating to such diagnosis, testing, or treatment. A copy of this form is valid to give my permission to release of information and records. I have received a copy of this release.

_____ _____
Authorized 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. The consumer must sign all other releases.

_____ _____
Parent or Guardian Signature **Date**

To those receiving information under this authorization: Federal and State laws and regulations (*42 CFR, Part 2 and 45 CFR Parts 160 & 164*) protect the information disclosed to you. You may not release it to any other person or entity without specific written consent from the individual it pertains to. You are subject to the same standards and laws of confidentiality as the originating holder of the records. **UNAUTHORIZED REDISCLOSURE BY RECIPIENT IS PROHIBITED.**