

Residential Program
Consent for Release and Exchange of Confidential Information

I, _____, hereby authorize the NWITC Residential Program to disclose
(Name of Patient – Please Print)

to and exchange the following information with:

(Name and Title of Person or Agency Receiving and/or Exchanging Information)

(Address including Zip Code)

(Telephone Number)

(Mark each item Yes or No)

_____ Identifying Information	_____ Progress Notes
_____ Admission Registration	_____ Psychiatric Consultation
_____ Diagnosis, Date of Service	_____ Psychological Evaluation
_____ General progress / Condition	_____ Academic Information
_____ History and Physical	_____ Discharge Summary
_____ Laboratory Reports	_____ Medical Discharge Summary
_____ Doctor's Orders	_____ Continuing Care Participation
_____ Consultations	_____ Family Questionnaire
_____ Treatment Plan	_____ Family Program Information
_____ Biopsychosocial Summary	_____ Other (specify) _____

The purpose or need for the exchange and disclosure of this information is to:

Facilitate Treatment Summarize Treatment Coordinate Continuing Care

Other (please state purpose clearly): _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically completion of my treatment at NWITC Residential Program or _____

Signature of Patient Date
Or parent, guardian or authorized representative

Signature of Witness Date

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of the client. This information has been disclosed to you from records whose confidentiality is protected by federal confidentiality rules (42 C.F.R., 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 C.F.R. 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 this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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(Name and Title of Person or Agency Receiving and/or Exchanging Information)

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_____ Identifying Information	_____ Progress Notes
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_____ Consultations	_____ Family Questionnaire
_____ Treatment Plan	_____ Family Program Information
_____ Biopsychosocial Summary	_____ Other (specify) _____

The purpose or need for the exchange and disclosure of this information is to:

Facilitate Treatment Summarize Treatment Coordinate Continuing Care

Other (please state purpose clearly): _____

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Signature of Patient Date
Or parent, guardian or authorized representative

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Basic Multi-Party Consent Form

Consent for Release and Exchange of Confidential Information

I, _____, authorize the following information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me.

The purpose or need for the exchange and disclosure of this information is to:

- Facilitate Treatment, Summarize Treatment, Coordinate Continuing Care, Enable the Squaxin Island Tribe and its various programs and service providers to evaluate my need for services from the Tribe, and provide and coordinate those services to me, Other (please state purpose clearly): _____

(Mark each item Yes or No)

Table with 2 columns: Item description and Mark each item Yes or No. Items include: My name and other personal Identifying Information, My status as a patient, Initial and subsequent evaluations of my service needs, Summaries of assessment results and history, Discharge plan(s) for alcohol/drug treatment and mental health services, Attendance, Date of discharge and discharge status, Summaries of service plan(s), progress and compliance, Other (specify) _____

I authorize that information to be disclosed between and among the following:

1) alcohol and/or drug treatment program(s): the Northwest Indian Treatment Center Residential Program, P.O. Box 477 Elma, Washington 98541; the Northwest Indian Treatment Center Outpatient Program, 100 SE Whitener Rd., Shelton, Washington 98584; [insert Name and Address for each]

2) health care provider(s): Squaxin Island Health and Human Services: [identify specific programs]

3) mental health agencies or providers named in the list of "Mental Health Providers" attached to this consent form that have provided me services since [date]

4) welfare agencies: the Squaxin Island Indian Child Welfare Program; [the local/county welfare agency and/or its designee]; the Department of Social and Health Services; [other]

5) the Squaxin Island Ta Ha Buts Learning Center and Education Program: [identify specific programs] Truancy Officer;

6) the Squaxin Island Tribe's Youth Court; Probation Officer; Parole Officer; Truancy Officer; [other referring agency]

7) [Name of the child(ren)'s attorney (law guardians)]; and

8) Other

Extended Multi-Party Consent Form

Consent for Release and Exchange of Confidential Information

I, _____, authorize the following information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me.

The purpose or need for the exchange and disclosure of this information is to:

- Facilitate Treatment Summarize Treatment Coordinate Continuing Care
- Enable the Squaxin Island Tribe and its various programs and service providers to evaluate my need for services from the Tribe, and provide and coordinate those services to me.
- Other (please state purpose clearly): _____

I authorize the following information to be disclosed:

(Mark each item Yes or No)

- | | |
|------------------------------------|-------------------------------------|
| _____ Identifying Information | _____ Progress Notes |
| _____ Admission Registration | _____ Psychiatric Consultation |
| _____ Diagnosis, Date of Service | _____ Psychological Evaluation |
| _____ General progress / Condition | _____ Academic Information |
| _____ History and Physical | _____ Discharge Summary |
| _____ Laboratory Reports | _____ Medical Discharge Summary |
| _____ Doctor's Orders | _____ Continuing Care Participation |
| _____ Consultations | _____ Family Questionnaire |
| _____ Treatment Plan | _____ Family Program Information |
| _____ Biopsychosocial Summary | _____ Other (specify) _____ |

I authorize that information to be disclosed between and among the following:

1) alcohol and/or drug treatment program(s): the Northwest Indian Treatment Center Residential Program, P.O. Box 477 Elma, Washington 98541; the Northwest Indian Treatment Center Outpatient Program, 100 SE Whitener Rd., Shelton, Washington 98584; _____; _____; _____;
[insert Name and Address for each]

2) health care provider(s): Squaxin Island Health and Human Services: [identify specific programs]
 _____; _____; _____;

3) mental health agencies or providers named in the list of "Mental Health Providers" attached to this consent form that have provided me services since [date] _____;

4) welfare agencies: the Squaxin Island Indian Child Welfare Program; [the local/county welfare agency and/or its designee]; the Department of Social and Health Services; [other] _____;

Multi-Party Consent Form

Consent for Release and Exchange of Confidential Information

_____, authorize the each and all of the following:

1) alcohol and/or drug treatment program(s): the Northwest Indian Treatment Center Residential Program, P.O. Box 477 Elma, Washington 98541; the Northwest Indian Treatment Center Outpatient Program, 100 SE Whitener Rd., Shelton, Washington 98584; _____; _____; _____; [insert Name and Address for each]

2) health care provider(s): Squaxin Island Health and Human Services: [identify specific programs] _____; _____; _____;

3) mental health agencies or providers named in the list of "Mental Health Providers" attached to this consent form that have provided me services since [date] _____;

4) welfare agencies: the Squaxin Island Indian Child Welfare Program; [the local/county welfare agency and/or its designee]; the Department of Social and Health Services; [other] _____;

5) the Squaxin Island Ta Ha Buts Learning Center and Education Program: [identify specific programs] Truancy Officer; _____; _____; _____;

6) the Squaxin Island Tribe's Youth Court; Probation Officer; Parole Officer; Truancy Officer; [other referring agency] _____; _____; _____;

7) _____ [Name of the child(ren)'s attorney (law guardians)]; and

8) Other _____; _____; _____

to communicate with and disclose to one another the following information: (Nature and amount of information should be as limited as possible and only disclosed to the extent necessary to meet the specific needs)

(Mark each item Yes or No)

Table with 2 columns of information types and checkboxes. Items include: Identifying Information, Admission Registration, Diagnosis, Date of Service, General progress / Condition, History and Physical, Laboratory Reports, Doctor's Orders, Consultations, Treatment Plan, Biopsychosocial Summary, Progress Notes, Psychiatric Consultation, Psychological Evaluation, Academic Information, Discharge Summary, Medical Discharge Summary, Continuing Care Participation, Family Questionnaire, Family Program Information, Other (specify) _____.

Prohibition on Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of the client. This information has been disclosed to you from records whose confidentiality is protected by federal confidentiality rules (42 C.F.R., 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 C.F.R. 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 this information to criminally investigate or prosecute any alcohol or drug abuse patient.