Addiction Services Release of Information

for Treatment, Payment & Health Care Operations

I authorize Cowlitz Indian Tribe Health and Human Services to disclose my private health information as specified below for all future treatment, payment, and health care operations purposes.

The nature of the information to be disclosed is:

> All Substance Use Disorder data necessary for treatment, payment, and health care operations purposes (including, but not limited to, medications and dosages, lab test results, treatment recommendations, billing and scheduling information, diagnoses, clinical notes. Psychotherapy notes & substance use disorder counseling session notes are not included).

The information specified above will be disclosed to any third party to whom disclosure is needed to support Cowlitz Indian Tribe Health and Human Services' treatment, payment, and health care operations.

This authorization will expire 90 days after termination of my treatment, unless an alternative expiration date or event is specified here _____.

I understand the Cowlitz Indian Tribe provides integrated care and utilizes a shared electronic health records system.

I understand that my record (or information contained in the record) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

I understand that my protected health information disclosed pursuant to this agreement may be subject to redisclosure by the recipient and in such cases may no longer be protected by state or federal rules of confidentiality.

I understand that I have the right to refuse to sign this form for authorization to disclose or use my private health information and that my refusal to sign this authorization will not adversely affect my ability to receive health care services, nor will treatment, payment, enrollment or eligibility for benefits be conditioned on whether I sign this authorization. I understand that my refusal to sign this form may limit sharing of information for coordination of care or billing.

I understand that I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed as described in this authorization unless action has already been taken in reliance on this authorization. This form has been explained to me in a language I understand, and I understand that I have a right to get a copy of this form.

_____

Client Signature Date

_____

Print Client Name Client Date of Birth

NOTE to receiving person or entity: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.