



Integrated 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 notes are not included).

The information specified above will be disclosed to my treating providers, health plans, third-party payers, entities participating in health information exchange activities supporting my care, and persons assisting in the operation of Cowlitz Indian Tribe Health and Human Services.

This authorization will expire 90 days after discharge from all applicable Cowlitz Indian Tribe Health and Human Services treatment programs, unless an alternative expiration date or event is specified here _____.

We come from a holistic approach to treatment and if you are involved in other services within Cowlitz Indian Tribe your treatment team may share information to identify the best options for achieving your wellness goals. Please be aware that Cowlitz Indian Tribe Health Services and Cowlitz Indian Tribe Behavior Health share an electronic health record called Epic. A widely used feature within Epic called "Care Everywhere" is a health information exchange system that allows medical records to be accessed and reviewed by the professionals on your care team across programs and agencies. This allows providers access to important treatment information needed to support your care. Please be aware that all health and behavioral health services are confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA). Information related to substance use disorder services and integrated behavioral health services have additional protections under 42 CFR Part 2 privacy regulations.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or other healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my protected health information disclosed pursuant to this agreement 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, and in such cases may no longer be protected by Part 2 confidentiality laws.

I understand I have the right to revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it. I understand that I may revoke consent by completing a Revocation of Consent to Release Information form, which can be obtained by contacting Health Information Management at 360-575-6232.

I agree that 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 Name

Client Date of Birth

Client Signature

Date

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