343-NonDOH March 2011

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

AUTHORIZATION FOR CARE COORDINATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes Seattle & King County Department of Public Health (SKCDPH) or its staff to exchange information (written or verbal) to the person(s) or organization(s) identified below for the purpose of ongoing care coordination. A Care Coordination Authorization form is required for each client.

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

I give my specific authorization for these records to be released, unless I check any of the boxes below. When checked, this consent **excludes** release of the following types of information:

- ☐ Drug or alcohol abuse diagnosis or treatment
- ☐ HIV (AIDS) testing/treatment
- ☐ Confirmed STD test results and/or treatment
- ☐ Psychiatric care/mental illness

Release of Information is authorized for:

_____	_____	_____
Client Name	Alias	Date of Birth

_____	_____	_____	_____
Signature of Client or Guardian	Relationship	Witness or Interpreter	Date

Records will be released to:

Agency Name	Telephone	Contact Person	Date

This authorization may be renewed three times.

Unless revoked or as otherwise provided herein, this authorization expires _____ (**insert either applicable date or event**). If this authorization requests that health information be used by or disclosed to the client's employer or a financial institution, this authorization will expire 90 days from the date signed.

_____	_____
Signature	Date
_____	_____
Signature	Date
_____	_____
Signature	Date

Client Rights

Your rights under federal and state law:

You may revoke this authorization at any time. It will be in writing. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable.

Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form.

When Public Health asks you to fill out this authorization, you are entitled to a copy.

You may ask to have this authorization expire sooner.

When Public Health discloses your health information, your protected health information can be subject to re-disclosure by the recipient and is no longer protected by Public Health.