



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
 Washington Health Professional Services
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Consent for the Release of Confidential Information

I, _____, of _____
 (Client Name) (Client address)

authorize Washington Health Professional Services (WHPS), to disclose to and/or receive information from: _____

(Name of person and/or organization and contact number to which disclosure is to be made)

I understand the purpose of this release is to allow WHPS to exchange information about me in any form including verbal, written, and electronic with the above named entity in order to facilitate appropriate treatment, medical care, monitoring; and to promote public safety. I also understand I am not eligible to participate in WHPS, if I decline to sign this or any additional requested releases.

Types of information that may be shared include, but are not limited to:

- Alcohol/drug use history, legal issues, and license status;
- Diagnostic impression, symptomology and treatment recommendations or services;
- Medical and/or psychiatric conditions;
- Prescribed medications;
- Results of toxicology testing; and
- Monitoring program compliance and status.

I understand my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent. I may revoke this consent at any time except to the extent action has been taken in reliance on it, and in any event this consent expires automatically as identified below.

Please specify the date, event, or condition upon which this consent expires **(initial one)**:

- _____ Ninety (90) days from the date listed below
- _____ Ninety (90) days after program completion
- _____ Other, specify length of time _____

 Client Signature

 Date

 Client Birthdate

 Client Driver License Number