

## Children and Youth with Special Health Care Needs Authorization to Release and Obtain Information

**1. AUTHORIZATION TO RELEASE INFORMATION:**

I, give my consent for \_\_\_\_\_ to release \_\_\_\_\_  
(Name and Address of CYSHCN Agency) (Health Care Information)  
 for \_\_\_\_\_ to the following professionals.  
(CYSHCN Client)

NAME <small>(Doctor/Hospital Agency/ Institutional Affiliation)</small>	ADDRESS	CONTACT PERSON

This authorization expires **90** days after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original

DATE	SIGNATURE <small>(Parent/Guardian/Self if imancipated minor)</small>	CYSHCN Agency Contact Person

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**2. AUTHORIZATION TO OBTAIN INFORMATION:**

I give my consent for \_\_\_\_\_ to obtain \_\_\_\_\_  
(Name and Address of CYSHCN Agency) (Health Care Information)  
 for \_\_\_\_\_ from the following professionals. I further give my consent to  
(CYSHCN Client)  
 the below named professional to disclose and release health care information for \_\_\_\_\_  
(CYSHCN Client)  
 to \_\_\_\_\_.  
(CYSHCN Agency)

NAME (Doctor/Hospital Agency/ Institutional Affiliation)	ADDRESS	CONTACT PERSON

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DATE	SIGNATURE (Parent/Guardian/Self if imancipated minor)	CYSHCN Agency Contact Person

**3. SPECIFIC RELEASE RELATED TO TREATMENT:**

I give my consent for \_\_\_\_\_ to release specific health care information  
 (Name and Address of CYSHCN Agency)  
 relating to treatment to the following programs to help the agencies provide \_\_\_\_\_  
 (CYSHCN Client)  
 with service.

HEALTH CARE TREATMENT	NAME (Doctor/Hospital/Agency/Institutional Affiliation)	ADDRESS	CONTACT PERSON
Alcohol/Other Drug Treatment			
STD Diagnosis & Treatment			
Mental Health & Psychiatric Disorders Treatment			
HIV/AIDS Testing, Diagnosis & Treatment			



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DATE	SIGNATURE (Parent/Guardian/Self if imancipated minor)	CYSHCN Agency Contact Person

I understand that the purpose of this release is to allow CYSHCN 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 promote public safety. I also understand that if I decline to sign this or any additional requested releases that I am not eligible to participate in CYSHCN.

I understand that alcohol/other drug treatment information relating to me is protected under federal law and cannot be disclosed to anyone else without my written consent unless permitted by law. I also understand I may **cancel** my consent to release alcohol/other drug treatment information at any time except to the extent that action has already been taken on it as allowed.

I understand that health care information, STD and HIV/AIDS information, and mental health information relating to me is protected by state law and cannot be disclosed to anyone else without my written consent unless permitted by law. I understand that I may **cancel** this consent at any time.

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

- Substance use history, legal issues, and license status
- Diagnostic impression, symptomology and treatment recommendations or services
- Medical and/or psychiatric conditions
- Prescribed medications
- Results of urine, blood, hair, etc. testing
- Monitoring program compliance and status



I understand that 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 that action has been taken in reliance on it and that in any event this consent expires automatically as follows;

Specification of 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) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please send the completed form to CYSHCN via email [CYSHCN@DOH.WA.GOV](mailto:CYSHCN@DOH.WA.GOV).

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).