Children 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 (Doctor/Hospital Agency/ Institutional Affiliation)	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 dame as the original

DATE	SIGNATURE (Parent/Guardian/Self if imancipated minor)	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

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 dame as the original

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

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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 **cance**l 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.

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 doh.information@doh.wa.gov.