GREATER COLUMBIA BEHAVIORAL HEALTH, LLC BH-ASO

101 N. Edison Street, Kennewick, WA 99336 - Phone: 509-737-2475 or 1-888-545-3022
Fax: 509-783-4165 or Secure Authorization Fax: 509-460-5238 - website: gcbhllc.org

Section 2500 Health Insurance Portability and Accountability Act (HIPAA)
Authorizing Sources: RCW 70.02, 71.05, 42 CFR, 45 CFR 160 to 165 (HIPAA)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by:

_____
Print Name

_____
Print Address

- ☐ Regarding myself
- ☐ Regarding the children/dependents in my custody:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

My health information may be disclosed under this Authorization to:

Greater Columbia Behavioral Health (ASO) CLIP Committee
101 N Edison St
Kennewick, WA 99336

Health information includes information collected from me, information received by the Greater Columbia Behavioral Health ASO, or information received by the Greater Columbia Behavioral Health ASO from a behavioral or physical health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or behavioral health, and the provision of my health care, or payment for my health care services.

I understand that the Greater Columbia Behavioral Health ASO is prohibited from disclosing information about treatment for psychiatric disorders/mental health, HIV/AIDS virus or sexually transmitted diseases and/or alcohol or drug abuse without my specified written authorization unless legally required or allowed by law. I understand that my records are protected by Washington state laws, and Federal Privacy and Confidentiality Rules (42 CFR Part 2, 45 CFR).

SECTION B: SCOPE OF USE OR DISCLOSURE

Check One:

Health information that may be used or disclosed through this Authorization is as follows:

- ☐ All health information about me, including my clinical records, collected or received by the Provider. This information may include, if applicable: Information pertaining to the identity, diagnosis, prognosis or

treatment for psychiatric disorders/behavioral health, HIV/AIDS virus or sexually transmitted diseases and/or alcohol or drug abuse maintained by a federally assisted alcohol or drug abuse program; or;

☐ All health information about me as described in the preceding checkbox, *excluding* the following:

_____
_____

☐ Specific health information *including only*:
_____
_____
_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

Information will be shared with Greater Columbia Behavioral Health – ASO CLIP Committee membership for purposes of consultation/resource recommendation. The following is the list of membership information will be disclosed to & received from:

- Amerigroup Real Solutions, Community Health Plan of Washington, Coordinated Care and Molina Healthcare
- CLIP Administration
- Comprehensive Healthcare
- GCBH ASO
- Quality Behavioral Health
- Treating inpatient and/or outpatient medication manager (when clinically appropriate)
- Youth's Current Mental Health Care Provider
- Youth's Family/Guardian(s)
- Youth School District (if applicable)
- DCYF
- DDA
- DSHS
- Other supports to the youth &/or family (please list)
- _____
- _____
- _____
- _____

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are):

Review of information by the Greater Columbia Behavioral Health ASO Youth CLIP Committee for service recommendations and care coordination as needed for non-Medicaid individuals.

SECTION D: EXPIRATION

This Authorization expires: _____

(Insert applicable event or date – mm/dd/yyyy) Maximum length of Authorization is one year from the date of signature.

SECTION E: OTHER IMPORTANT INFORMATION

I understand that the Greater Columbia Behavioral Health ASO cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I understand that, except when I am (i) receiving research-related treatment, (ii) receiving health care solely for the purpose of creating information for disclosure to a third party, (iii) enrolling in the health plan or seeking eligibility for benefits I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from the Greater Columbia Behavioral Health ASO contracted providers or those contracted through my assigned Medicaid managed care plan. Refusal to sign this Authorization will result in the Greater Columbia Behavioral Health ASO Youth Community Resource Committee declining to convene. The Greater Columbia Behavioral Health ASO will not be able to process and refer applications for Children's Long-term Inpatient Treatment (CLIP) without a signed Authorization.

I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Greater Columbia Behavioral Health ASO in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that I must provide any notice of revocation to the Privacy Officer at Greater Columbia Behavioral Health ASO. The address of the privacy officer is Greater Columbia Behavioral Health, LLC, 101 N Edison St, Kennewick, WA 99336 and the phone number is (509) 737--2475. Individuals revoking this authorization may be asked to sign a Greater Columbia Behavioral Health ASO revocation form.

I have read and understand the terms of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:_____ Date:_____

Print Client's full name:_____

Client's Home Address:_____

Client's Home Telephone:_____ Date of Birth:_____

When client is not competent to give consent, the signature of a parent, guardian, or other authorized legal representative is required.

Signature of legal representative:_____ Date:_____

Print Name:_____

Relationship of representative to client:_____

Witness:_____ Date:_____

SUBSTANCE ABUSE REDISCLOSURE NOTICE
Greater Columbia Behavioral Health
101 N. Edison, Kennewick, WA 99336

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.

This information has been disclosed to you from records protected by federal confidentiality rules governing federally assisted drug or alcohol abuse programs (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is not sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.