AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE GCBH BH-ASO YOUTH ACCESS AND RESOURCE PROGRAM COMMUNITY MULTIDISCIPLINARY TEAM (MDT)

Name: _____ Date: _____

By signing below, I authorize the Community Collaboration Workgroup, which includes staff from the following entities:

ESD 123	Blue Mountain Counseling	Comprehensive Healthcare	College Place School District
DDA	Columbia School District	Dayton School District	WW and Columbia JJC
Catholic Charities	CHPW	Coordinated Care	Molina
Wellpoint	Walla Walla School District	Greater Columbia BH-ASO	Coalition of Youth and Families
Walla Walla Fire	Columbia County Health System	Youth Cannabis and Tobacco Prevention Program	

To communicate with and disclose to one another the following information (Please check all appropriate boxes):

☐Initial and subsequent evaluations of my service needs by the Community Collaboration and its members

☐Current and past Mental Health Treatment Programs, with dates

☐Current and past Substance Use Disorder Treatment Programs, with dates

☐Current and past Emergency Department visits, with dates

☐Past or present Mental Health Problems or Diagnosis

☐Past or present Substance Use Disorder Problems or Diagnosis

☐Past or present Physical Health Problems

☐Other: _____

The purpose of the release/disclosure is to coordinate the following treatment activities: assessment, referral, medical, substance use disorders, mental health, vocational, shelter or housing services.

By signing this authorization, I understand the following:

- When I am asked to fill out this authorization, I am entitled to a copy. Initial if declining a copy: _____
- I have the right to revoke this authorization at any time. Any revocation will not take effect if action has already been taken based on the original authorization. Without my express revocation, this authorization will expire in one year from the signature date below.
- The information disclosed and redisclosed may contain information on my current/past: Mental Health, substance or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by, with the exception of, Substance Use Disorder records which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2.
- I understand that this authorization is voluntary and that I may refuse to sign this form. My refusal to sign will not affect the treatment or services I receive from specific providers but will limit the ability of the workgroup members to discuss my needs and to coordinate my care.

Signature of Individual or their representative able to give authorization:	Date:
If signed by a person other than the Individual, please print your name, provide reason, relationship to the Individual, and description of authority	

All disclosures and redisclosures must be accompanied by the following notice: "This information has been disclosed to you from records protected by federal confidentiality rules (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 the 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 individual seeking alcohol or drug use treatment.