Kent Youth & Family Services

232 S. Second Ave. #201
Kent, WA 98032
253-859-0300; fax 253-859-0745

Authorization For Use and Disclosure of Protected Health Information

Client Name:_____ Date of Birth:_____

Hereby authorizes Kent Youth & Family Services to:

☐ Disclose information to: ☐ Obtain* information from: ☐ Exchange* information with:

* I authorize the person or organization named below to disclose information to Kent Youth and Family Services.

Name or Organization: _____

Address or Telephone: _____

_____

Information to be disclosed: (Please initial each specific authorization)

____Mental/Behavioral Health I understand that my records may contain sensitive mental health information, assessment results, diagnosis and/or treatment for a mental health disorder.	**_____ Drug and Alcohol** I understand that my records may contain information, diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for records to be released (CFR 42, Part 2).	**_____ STD/ AIDS/ HIV** I understand that my records contain information regarding testing, diagnosis, or treatment of STD/HIV/AIDS. I give my specific authorization for these records to be released (RCW 70.24.105)
_____ Insurance/ Billing I understand that Kent Youth and Family Services is part of the NAVOS RSN and uses a third party billing entity for services.	**_____ Psychiatric** I understand that Kent Youth and Family Services contracts with NAVOS RSN for psychiatric services and these records are a part of your clinical file.	**_____ Physical Health** I understand that Kent Youth and Family Services may request medical records for the purpose of coordination of care.
_____ Urinalysis Results	**_____ Academic Performance**	**_____ Attendance to Treatment**

For the purpose of :

_____

_____

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, UNLESS THE AGENCY HAS ALREADY DISCLOSED THE INFORMATION. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE IN NINTY (90) DAYS FROM THE SIGNATURE DATE OR UPON THE INDIVIDUALS DISCHARGE FROM SERVICES, WHICH EVER IS LONGER.

_____ _____

Signature of Client/ Legal Representative Date

_____

Relationship or status if signed by anyone other than client (parent, legal guardian, personal representative, etc.)

REDISCLOSURE PROHIBITED:

This information has been disclosed to you from records whose confidentiality is protected by state or federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose