Center for Justice Social Work
Soundview Wellness
P/F: 360.218.4645

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Client Name: _____ DOB: _____

I hereby authorize the mutual exchange of *confidential information* regarding the above-named patient between:

Center for Justice Social Work
Soundview Wellness
3710 168th St NE
Arlington, WA 98223

AND

Name: _____
Phone: _____
Fax: _____
Email: _____

The exchange of information is for the following purpose of (please check all that apply):

- ☐Consultation
- ☐Continuity of care
- ☐Coordination of care
- ☐Educating natural supports
- ☐Housing services/arrangements
- ☐Payment and financial matters
- ☐Referral for other services
- ☐Therapist transition
- ☐Treatment/Intervention planning
- ☐Other (specify)_____

I authorize the release of *any and all of the following medical, mental health, and/or substance use disorder information, as specified*, which may be contained in my records (check all that apply):

- ☐Behavioral health diagnosis
- ☐Crisis/Safety plan
- ☐Discharge summary
- ☐Financial information
- ☐Housing information
- ☐Intake assessment
- ☐List of services provided
- ☐Medical diagnosis
- ☐Medical history/profile
- ☐Mental health assessment
- ☐Treatment/Intervention plan
- ☐Treatment/Intervention plan review
- ☐Treatment/Progress notes/summary
- ☐Other (specify)_____

I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105) ☐Approve ☐Deny

As the individual signing, I understand that the terms of this Authorization, including:

1. I am giving my permission to the Center for Justice Social Work and Soundview Wellness to disclose my confidential health records.
2. That my signing of this Authorization is voluntary.
3. My health information is protected by federal HIPAA Privacy regulations and 42 CFR Part 2.
4. If the organization authorized to receive the information is not a healthcare provider covered by federal privacy regulations, the released information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s).
5. Staff of Center for Justice Social Work and Soundview Wellness may condition treatment on the signing of this Authorization.
6. A photocopy of this Authorization is as valid as the original, and that I am entitled to a copy of this Authorization. Center for Justice Social Work and Soundview Wellness reserves the right to utilize any and all secure methods for releasing the information specified above.
7. Paper or electronic copies of my records may be used to facilitate disclosure of my information.
8. I understand that I may see and receive a copy of the information described in this Authorization if I request it in writing.
9. I understand that I have the right to refuse to sign this Authorization.
10. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.
11. I understand the following information related to minors:
    a. A minor has the right to consent to medical treatment. They also have the right to control information related to that treatment.
    b. A competent minor patient's signature is required to release information related to the care of birth control for minors deemed mature; treatment for HIV/AIDS sexually transmitted diseases for patients age 14 and above [RCW 70.05.070, RCW 70.24.110]; to receive HIV/AIDS or STD test results for patients age 15 and above [RCW 70.24.105]; outpatient treatment for alcoholism and drug abuse for patients age 13 and above; [RCW 70.96A.095]; and mental health conditions for patients age 13 and above [RCW 71.34.030(1)]

Unless revoked earlier by me, this Authorization shall expire 1 year after the signature date, or upon discharge from services at Center for Justice Social Work and Soundview Wellness, whichever is *later*.

NOTICE: Information approved for disclosure based on this Authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

X_____ Date:_____

Signature of client, client's parent/guardian/legal representative

X_____ Date:_____

Witness signature