South Kitsap School District Multi-Party Consent for Release of Information for School Based Health Care

Complies with HIPAA and 42 CFR Part 2

I, _____, authorize the following agencies to collaborate and coordinate services.

___ Peninsula Community Health Services
___Burley Glenwood Elementary
___ Cedar Heights Middle School
___ Discovery Alternative High School
___ East Port Orchard Elementary
___ Explorer Academy
___ Hidden Creek Elementary
___ John Sedgwick Middle School
___Manchester Elementary
___Marcus Whitman Middle School
___ Mullenix Ridge Elementary
___Olalla Elementary
___ Orchard Heights Elementary
___ Sidney Glen Elementary
___ South Colby Elementary
___ South Kitsap High School
___ Sunnyslope Elementary

Purpose of this disclosure:

☐Verification of treatment status
☐ Assist in appropriate treatment placements
☐ Exchange and verify treatment planning information
☐ Billing purposes
☐ Collaboration and coordination of care
☐ Other: _____

To communicate with and disclose to one another the following information:

☐ Substance use disorder assessment and summary, diagnosis, treatment attendance, recommendations, prognosis, progress information and discharge summary
☐ Current medical information including diagnosis, prognosis
☐ Relevant past medical information including diagnosis, prognosis
☐ Current medications and compliance
☐ Physical Exam
☐ Lab results
☐ TB rest results and/or screening
☐ UA and other drug alcohol monitoring results
☐ Psychological and/or mental health assessments, diagnosis, and treatment recommendations, prognosis, progress information and discharge summary.
☐ Other: _____

Records concerning substance treatment and/or sexually transmitted diseases may NOT be redisclosed by you unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by regulation. (42 CFR Part 2 and RCW 70.24). An authorization for the release of medical or mental health information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute a Substance Use Disorder Patient.

Unless otherwise indicated, this release specifically allows the disclosure of mental health/psychological treatment (45 CFR Parts 160 and 164); drug/alcohol or other substance treatment (42 CFR Part 2); and the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

This authorization covers verbal, paper and/or electronic disclosures. A copy or fax shall be considered valid in lieu of original. **This release may be revoked, in writing, at any time within the exception and to the extent that disclosure has already occurred and has been taken in reliance on it, and that in any event this consent expires automatically as follows:**

☐ One month following the date I stop receiving services from PCHS or its School Based Clinics
☐ The following date: _____

_____ Date: _____
Signature of Parent/Guardian /Adult Sibling:

_____ Date: _____
Signature of Student Youth (required for 13 and older)

Witness_____ Date: _____

Created on 05/06/2021