North Intertribal Vocational Rehabilitation Program

3205 Northwest Ave #10
Bellingham, WA 98225

Phone: 360-671-7626
Fax: 360-733-3061

CONSENT TO RELEASE HEALTH CARE INFORMATION

Participant Name	Date of Birth	Phone
Address		

I the undersigned patient authorize the Provider listed below to disclose/receive copies of the specified records as he/she has directed

Name of health provider or entity to release this information:
Address of health provider or entity to release this information:

The information disclosed/received by _____, a Vocational Rehabilitation Counselor at the North Intertribal Vocational Rehabilitation Program will be use in the following manner: □ To document eligibility to receive services from NIVRP, □ To coordinate services with the disclosing party

❑ Other_____

INFORMATION TO BE RELEASED TO NIVRP:

Specify desired information to be released: _____

_____

_____

_____

SPECIFIC AUTHORIZATIONS

This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, only if I place my initials on the appropriate line, below

_____ Mental Health Services _____ Drug and/or alcohol abuse diagnosis, treatment, or referral

_____ Communicable diseases including sexually transmitted diseases (e.g. HIV/AIDS/AIDS Related illness)

1. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 & 164 and cannot be disclosed without be written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis. Testing, and/or treatment for communicable diseases, including sexually transmitted diseases (e.g. Tuberculosis, HIV/AIDS-AID-related illness), mental health services, drug and/or alcohol services.
2. The recipient of the information is not a health plan or provider covered by federal or state privacy laws, then the information used, disclosed, and received under this authorization may be subject and no longer protected by those laws. Federal or state law, however, may restrict redisclosure of HIV/AIDS/STD's, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information to someone else.
3. I may refuse to sign this authorization. My refusal may adversely affect my ability to receive treatment, payment for services, program enrollment or eligibility for benefits, from the North Intertribal Vocational Rehabilitation Program.
4. I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it
5. Unless revoked, this authorization automatically expires 1 (one) year from date of signature. _____

I have read this authorization and understand it.

Signature of Client:_____ Signature Date:_____

Signature of Parent or Legal Guardian:_____ Signature Date:_____