Bremerton 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
___ Armin Jahr Elementary
___ Bremerton home Link Program
___ Crownhill Elementary
___ Kitsap Lake Elementary
___ Naval Avenue Early Learning Center
___ Bremerton High School
___ Renaissance High School
___ West Sound Technical Center
___ View Ridge Arts Academy
___ West Hills Stem Academy
___ Washington Youth Academy

Purpose of this disclosure:

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

Signature of Parent/Guardian /Adult Sibling: ________________________________
Date: __________________

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

Witness ________________________________
Date: __________________

Created on 10/04/19