Central 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
- Brownsville Elementary
- Clear Creek Elementary
- Cottonwood Elementary
- Cougar Valley Elementary
- Emerald Heights Elementary
- Esquire Hills Elementary
- Ridgetop Middle School
- CK High School
- Olympic High School
- Green Mountain Elementary
- Hawk at Jackson Park
- Pinecrest Elementary
- Silver Ridge Elementary
- Silverdale Elementary
- Woodlands Elementary
- CK Middle School
- Fairview Middle School
- Klahowya Secondary School (6-12)

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:

____________________________
Signature of Student Youth (required for 13 and older)

Witness

Created on 10/04/19