Northwest Indian Treatment Center
100 SE Whitener Rd., Shelton, Washington 98584 360-426-1582
Outpatient Program
Consent for Release and Exchange of Confidential Information

I, ____, hereby authorize the NWITC Outpatient Program to disclose
(***Name of Patient – Please Print***)
to and exchange the following information with:
____
(***Name and Title of Person or Agency Receiving and/or Exchanging Information***)
____ _____________________________
(***Address including Zip Code)*** ***(Telephone Number***)

(Mark each item Yes or No)

_______ Identifying Information
_______ Admission Registration
_______ Diagnosis, Date of Service
_______ General progress / Condition
_______ History and Physical
_______ Laboratory Reports
_______ Doctor's Orders
_______ Consultations
_______ Treatment Plan
_______ Biopsychosocial Summary
________ Progress Notes
________ Psychiatric Consultation
________ Psychological Evaluation
________ Academic Information
________ Discharge Summary
________ Medical Discharge Summary
________ Continuing Care Participation
________ Family Questionnaire
________ Family Program Information
________ Other (*specify*) _______________

The purpose or need for the exchange and disclosure of this information is to:

☐ Facilitate Treatment ☐ Summarize Treatment ☐ Coordinate Continuing Care

☐ Other (*please state purpose clearly*): ____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically completion of my treatment at NWITC Outpatient Program or [other] ☐ ________________________________

____ ____

Signature of Patient Date Signature of Witness Date
Or parent, guardian or authorized representative

Prohibition on Redisclosure of Confidential Information
This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of the client. This information has been disclosed to you from records whose confidentiality is protected by federal confidentiality rules (42 C.F.R., Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Basic Multi-Party Consent Form
Consent for Release and Exchange of Confidential Information

I, ____, authorize the following information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me.

The purpose or need for the exchange and disclosure of this information is to:

☐ Facilitate Treatment ☐ Summarize Treatment ☐ Coordinate Continuing Care

☐ Enable the Squaxin Island Tribe and its various programs and service providers to evaluate my need for services from the Tribe, and provide and coordinate those services to me.

☐ Other (*please state purpose clearly*): ____

(Mark each item Yes or No)

_______	My name and other personal Identifying Information	________	Discharge plan(s) for alcohol/drug treatment and mental health services
_______	My status as a patient	________	Attendance
_______	Initial and subsequent evaluations of service needs	________	Date of discharge and discharge status
_______	Summaries of assessment results and history	________	Summaries of service plan(s), progress and compliance
_______		________	Other (*specify*) ______________

I authorize that information to be disclosed between and among the following:

1) Alcohol and/or drug treatment program(s): the Northwest Indian Treatment Center Residential Program, P.O. Box 477 Elma, Washington 98541; the Northwest Indian Treatment Center Outpatient Program, 100 SE Whitener Rd., Shelton, Washington 98584; ☐ ______________________; ☐ ______________________; [insert Name and Address for each]

2) Health care provider(s): Squaxin Island Health and Human Services: [identify specific programs]
☐ ______________________; ☐ ______________________;

3) mental health agencies or providers named in the list of "Mental Health Providers" attached to this consent form that have provided me services since [date] _________;

4) Welfare agencies: the Squaxin Island Indian Child Welfare Program; [the local/county welfare agency and/or its designee]; the Department of Social and Health Services; [other] ☐ ______________________;

5) The Squaxin Island Ta Ha Buts Learning Center and Education Program: [identify specific programs] ☐ Truancy Officer; ☐ ______________________;

6) The Squaxin Island Tribe's Youth Court; ☐ Probation Officer; ☐ Parole Officer;

☐ Truancy Officer; ☐ [other referring agency] ______________________;

7) ☐ ______________________

[Name of the child(ren)'s attorney (law guardians)]; and

8) Other ☐ ______________________; ☐ ______________________;

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one month following the date I stop receiving services from the Core Group or any of its members, whichever is later.

Signature of Patient Date

Signature of Parent, Guardian or Authorized Representative Date

Signature of Witness Date

Extended Multi-Party Consent Form
Consent for Release and Exchange of Confidential Information

I, ____, authorize the following information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me.

The purpose or need for the exchange and disclosure of this information is to:

☐ Facilitate Treatment ☐ Summarize Treatment ☐ Coordinate Continuing Care ☐ Enable the Squaxin Island Tribe and its various programs and service providers to evaluate my need for services from the Tribe, and provide and coordinate those services to me. ☐ Other (*please state purpose clearly*): ____

I authorize the following information to be disclosed:

(Mark each item Yes or No)

_______ Identifying Information
_______ Admission Registration
_______ Diagnosis, Date of Service
_______ General progress / Condition
_______ History and Physical
_______ Laboratory Reports
_______ Doctor's Orders
_______ Consultations
_______ Treatment Plan
_______ Biopsychosocial Summary
________ Progress Notes
________ Psychiatric Consultation
________ Psychological Evaluation
________ Academic Information
________ Discharge Summary
________ Medical Discharge Summary
________ Continuing Care Participation
________ Family Questionnaire
________ Family Program Information
________ Other (*specify*) ______________

I authorize that information to be disclosed between and among the following:

1) Alcohol and/or drug treatment program(s): the Northwest Indian Treatment Center Residential Program, P.O. Box 477 Elma, Washington 98541; the Northwest Indian Treatment Center Outpatient Program, 100 SE Whitener Rd., Shelton, Washington 98584; ☐ ______________________; ☐ ______________________; ☐ ________________;

[insert Name and Address for each]

2) Health care provider(s): Squaxin Island Health and Human Services: [identify specific programs] ☐ ______________________; ☐ ______________________; ☐ ____________________;

3) Mental health agencies or providers named in the list of "Mental Health Providers" attached to this consent form that have provided me services since [date] ____________;

4) Welfare agencies: the Squaxin Island Indian Child Welfare Program; [the local/county welfare agency and/or its designee]; the Department of Social and Health Services; [other] ☐ ______________________;

5) The Squaxin Island Ta Ha Buts Learning Center and Education Program: [identify specific programs] ☐ Truancy Officer; ☐ ______________________; ☐

6) The Squaxin Island Tribe's Youth Court; ☐ Probation Officer; ☐ Parole Officer; ☐ Truancy Officer; ☐ [other referring agency] ______________________;

7) ☐ ______________________

[Name of the child(ren)'s attorney (law guardians)]; and

8) Other ☐ ______________________;

The purpose or need for the exchange and disclosure of this information is to:

☐ Facilitate Treatment ☐ Summarize Treatment ☐ Coordinate Continuing Care ☐ Enable the Squaxin Island Tribe and its various programs and service providers to evaluate my need for services from the Tribe, and provide and coordinate those services to me.

☐ Other (*please state purpose clearly*): ____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one month following the date I stop receiving services from the Core Group or any of its members, whichever is later.

_______________________________________ _______________________
Signature of Patient Date Signature of Parent, Guardian Date
or Authorized Representative

____
Signature of Witness Date

Prohibition on Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of the client. This information has been disclosed to you from records whose confidentiality is protected by federal confidentiality rules (42 C.F.R., Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.