PIONEER HUMAN SERVICES
A CHANCE FOR CHANGE

Authorization to Release Protected Health Information

7440 West Marginal Way S., Seattle, WA 98108 • Ph: (206) 768-1990 • Fax: (206) 768-8910

This information is to be released and/or exchanged between and among the identified agencies or persons solely for the purposes of obtaining accurate and complete history for agency records, and/or, for the process of consideration, treatment and follow-up related to participation in agency programs, including but not limited to clinical trials research, day treatment, and/or residential care. Any other use is strictly prohibited under federal law. I understand that the information may/will include treatment for mental and/or physical illness, human immunodeficiency syndrome (HIV) or tests for HIV or AIDS.

Name: _____ Date of Birth:_____ Last 4 digits of SSN:_____

I hereby Authorize Pioneer Human Services To:

☐ Obtain information from ☐ Provide information to ☐ Conduct mutual exchange of information

Name of Facility/Program/Organization: _____

Address: _____

Provider/person_____ Phone_____ Fax _____

If conducting mutual information exchange – add second Facility/Program/Organization:
Name of Facility/Program/Organization: _____

Address: _____

Provider/person_____ Phone_____ Fax _____

I Authorize the Release of the Following Information:

☐ Discharge Summary	☐ Progress Notes	☐ All Substance Use records
☐ Psychological Evaluation	☐ Physician Orders	☐ Re-disclosure of UA results
☐ Treatment Plan	☐ Social/Occupational Hx	☐ Monthly SUD Status Reports
☐ History and Physical	☐ Medication Records	☐ SUD Assessment Summation
☐ Admission Note	☐ Psychological Testing	☐ Monthly MH Status Reports
☐ Consultations	☐ Communications	☐ MH Assessment Summation
☐ Lab Reports (ECG, blood, MRI/CT, etc.)	☐ HIV+, AIDS info / status ☐ HBV, HCV info / status	☐ Other, specify _____

Amount of Information to be Disclosed:

☐ Previous 3 Months ☐ Most Recent Admission ☐ Other, specify _____

Purpose: I understand that this information will be used for the following (Check all that apply)

☐ Evaluation / Treatment ☐ Legal Purposes ☐ Insurance / Billing Purposes
☐ Other, specify _____

Expiration Date of this authorization: ___/____/____

By signing this form, I acknowledge that I have read and agree to the terms on this form.

Signature_____ Date: ____/____/___

Signature_____ Date: ____/____/___
Legal representative if not signed by client

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness, alcohol/drug use and/or abuse (Title 42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis.

I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may revoke this consent at any time in writing to designated Pioneer Human Services staff, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which the disclosure is hereby authorized. I further understand the refusal to allow disclosure may be considered in violation of my parole or probation.

NOTE: This information has been disclosed to you from records protected by Federal Confidentiality Rules. 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 Title 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.