North Sound Behavioral Health Ombuds
Serving Island, San Juan, Skagit, Snohomish & Whatcom Counties
330 Pacific Place Mount Vernon, WA 98273
360-416-7004 Toll Free: 1-888-336-6164 Fax 360-416-7550
Form Updated 1-1-2020

Consent for the Release of Confidential Information

Name: ____________________

Date of Birth: ____________________ Telephone: ____________________

Address: ____________________

I, ____________________ request North Sound Behavioral Health Ombuds (a program within Community Action of Skagit County) and ____________________ to disclose the following specific information:
(Name of person/organization to which disclosure is to be made)

Please initial all that apply:
____Complete Intake/Assessment ____Service Notes & Treatment Plans ____Progress/Clinical Notes ____Discharge Summary
____Medication History Other: ____________________

I also give my consent for the use or disclosure of any health care information related to testing, diagnosis, and/or treatment of the following:

Please initial all that apply:
____Psychiatric Information ____Drug and/or Alcohol Use____ Substance Use Assessment ____Psychotherapy Notes
____HIV/AIDS Virus ____Sexually Transmitted Diseases

The purpose of the release of my confidential information within North Sound Behavioral Health Ombuds (a program within Community Action of Skagit County) is to provide advocacy and support through the complaint, grievance, appeal, fair (administrative) hearing, and Health Care Authority board of appeals process.

I understand that my treatment records may be protected under Washington State law, the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. I understand I may revoke this consent of my confidential information in **writing** at any time, but I realize that information may have already been exchanged prior to revocation. I understand that I have the right to not sign this authorization, but I recognize that if I refuse to sign this consent, Ombuds will not be able to assist me with the resolution of my concern. I understand that my protected health information disclosed pursuant to this agreement may be subject to redisclosure by the recipient and in such cases may no longer be protected by state or federal rules of confidentiality.

Signature Date: ____________________
(Valid for 1 year, unless another expiration date or event is noted here :____________________)

Signature of Individual: ____________________

Signature of person signing form if not Individual: ____________________

Describe authority to sign on behalf of Individual: ____________________
If the individual is under 13 years of age, or is an adult with a court appointed guardian, the individual's parent or guardian must sign this release.