Patient Consent and Disclosure of Records and Information

Child Study and Treatment Center
8805 Steilacoom Blvd. SW Lakewood, WA 98498-4771

I, _____hereby authorize:
(Parent/Legal Guardian/Patient age 13 and over)

Check **one** only:

Patient Name: _____
Birthdate: _____

_____ the disclosure of information by
_____ the exchange of information between
_____ the release of information to

Child Study and Treatment Center, 8805 Steilacoom Blvd. SW, Lakewood, WA 98498-4771 (to, and, by) (name of person or agency, phone number and address)

_____

_____

_____

I am requesting that the patient's mental health records be sent to the above-named person/agency.

The purpose and need for disclosure is to PROVIDE CONTINUITY OF CARE and/or _____

_____

I may revoke this authorization at any time unless action has been taken in reliance thereon, and in any event, 90 days after my discharge from treatment, or upon the following condition or events:

_____

I understand that CSTC will keep a record of the health care services provided to me/my child. I can ask to see and copy that record at any time. CSTC will not disclose my/my child's records to others unless the law authorizes or compels them to do so.

I also understand that once CSTC has disclosed my/my child's records to another person/agency, that person/agency is prohibited from redisclosing this information without my written consent, or as otherwise permitted by law. I also understand that in the case of alcohol and drug abuse patient records, any disclosure made is subject to, and protected by the regulations contained in Title 42 of the Code of Federal Regulations, Part 2. These rules prohibit further disclosure of alcohol and drug abuse patient records unless expressly permitted by written consent of the person to whom it pertains or as other permitted by 42 CFR, Part 2. A general authorization for the release of medical information is **not** sufficient for this purpose. The Federal rules also restrict the use of such information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Date Parent/Guardian Signature

_____ _____
Witness (optional) Patient's Signature (age 13 and over)