

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.

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)

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

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.