COMMUNITY HEALTH PLAN of Washington™
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Community Health Plan of Washington
Authorization to Release Confidential Substance Use Disorder Treatment Information

This form is used to release your protected substance use disorder (SUD) treatment (alcohol or drug treatment) information (Part 2 Protected Records) as required by state and federal privacy laws. Your authorization allows Community Health Plan of Washington (CHPW) to release your Part 2 Protected Records to person(s) or organization(s) that you specifically name.

Outpatient SUD treatment: under Washington law, a minor member must consent to the release of their Part 2 Protected Records for **outpatient** SUD treatment, if they have obtained such treatment without parental consent.

Inpatient SUD treatment: under Washington law, a minor 13 years of age or older may receive inpatient SUD treatment without parental consent **only** if the Department of Social and Health Services (DSHS) determines they are a "child in need of services." Any written consent for disclosure of patient identifying information of a minor who has been deemed a "child in need of services" by DSHS may be given **only** by the minor member. On the other hand, any written consent for disclosure of patient identifying information of a minor who has not been deemed a "child in need of services" by DSHS must be given by **both** the minor member and their parent, guardian, or authorized representative.

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

If parent/guardian consent is for information about inpatient SUD treatment of a minor, please list the minor's name:

_____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

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2. The above-named member hereby authorizes CHPW to disclose information concerning the member's name and other personal identifying information, their status as a patient obtaining diagnosis, treatment, and referral for treatment with a Part 2 Program, and medications to the below person(s) or organization(s) (attach separate sheet if needed):

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

3. Check the box(es) below to tell CHPW the specific information you want disclosed (nature and amount of information to be disclosed, as limited as possible):

☐ All information (claims, appeals, billing, enrollment, etc.).

☐ All benefit claims data related to SUD treatment.

☐ Appeals.

☐ Specific claims (specify date(s) of service, claim number, etc.): _____

☐ Billing/enrollment information.

☐ Records related to my SUD treatment at a Part 2 Program.

☐ Other (please specify): _____

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4. The purpose of the disclosure herein is to: _____

5. I understand that my Part 2 Protected Records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time (verbally or in writing) to the extent that action has been taken in reliance on it, and that **in any event his consent expires automatically as follows** (specify date, event or condition upon which consent expires):

_____

_____ _____ _____
Member Printed Name **Member Phone** **Date**

_____
Member Signature

5a. Signature of parent or guardian for dependent minor member's Part 2 Protected **inpatient** SUD treatment records:

_____ _____ _____
Parent/Guardian Printed Name **Parent/Guardian Phone** **Date**

_____
Parent/Guardian Signature

☐ Check here if you are signing as a personal representative (person authorized to sign in lieu of member) and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the member: _____
Give copy of signed form to member and maintain copy in member record.

6. Notice prohibiting re-disclosure of patient identifying information:

This information which has been disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

7. Send the completed, signed request to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

If you are a Washington Apple Health (Medicaid) Member	**If you are a CHPW Medicare Advantage Member**
Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/member-center/member-rights/	Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/

If you are a Cascade Select Member Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://individualandfamily.chpw.org/member-center/member-rights/	