Washington State Health Care Authority

Consent to Coordinate Care and Treatment

Completion Instructions for Form

Purpose of this form:

Our goal is to provide you with the best care possible. To do this, your health care providers may need to communicate and work together.

Federal laws require that we get your permission to share your substance use disorder treatment records to coordinate your care. However, you do not need to sign this form to receive care or services.

Your treatment records are strictly protected – There are requirements in federal law (42 CFR Part 2) that encourage you to seek treatment for substance use disorder without fear of consequences. These requirements protect the privacy of your treatment records and, in most instances, prohibit sharing your records without your permission.

Who will my information be shared with? – You are in control of who has access to your treatment records. You can provide a general approval, such as "I give my permission to share my substance use disorder treatment information with all individual(s) or organization(s) with whom I have a past, current, or future treating provider relationship." Or, you can choose to be very specific and share your information with only the individuals or entities that you clearly name, such as "Dr. Jane Smith at ABC Clinic." You can choose how long you want to share your information and you have the ability to change your mind later.

Definitions

Treating provider – A treating provider includes anyone who has provided you diagnoses, evaluation, treatment, or consultation, for any condition, or anyone you have agreed or legally required to receive diagnoses, evaluation, treatment, or consultation from.

Health Information Exchange – A secure electronic system that sends your treatment medical information and allows doctors, mental health providers, nurses, pharmacists, and other health care providers to appropriately access and securely share this information—improving the speed, quality, safety and cost of your care.

Personal information

Note: Patient identification label may be affixed here in lieu of completing this section.

First name	Middle initial	Last name	Date of Birth (mm/dd/yyyy)	ZIP Code

SECTION 1: What information am I agreeing to share?

I give my permission to share the following information (please select one or both):

☐ **Option 1:** Substance Use Disorder (SUD) treatment records maintained by my providers (including, but not limited to, medications and dosages, lab test results, clinic visits, diagnostic information, discharge summary etc.)

☐ **Option 2:** Claims data related to Substance Use Disorder (SUD) treatment, which include only a summary of my diagnoses and services received

☐ **Option 3** "I select both Option 1 and Option 2"

SECTION 2: Who may share my Substance Use Disorder (SUD) information?

This section identifies which of your providers can share your information.

Please select one or both of the following options:

☐ **Option 1:** "I give permission for all of my past, current, or future treating providers to share my substance use disorder treatment information."

☐ **Option 2:** "I give permission for these specific individual(s) or organization(s) to share my substance use disorder treatment information."

Name of the individual(s) and/ or healthcare organization(s) with whom I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

☐ **Option 3:** "I select both Option 1 and Option 2"

SECTION 3: Who do I want to share my information with?

This section identifies who can receive your information.

I give my permission to share the following information (please select one or both):

☐ **Option 1:** Providers may choose to send and receive patient treatment information through a secure electronic system called a Health Information Exchange (HIE). Doctors, mental health providers, nurses, pharmacists, and other health care providers are only allowed to receive and share your information from an HIE if they have the right permissions to do so.

"I understand that my past or current treating providers may currently use, or plan to use, the following HIE to manage my information: _____. I agree to share my information through the HIE with all individual(s) or organization(s) that I have a past, current or future treating provider relationship with."

☐ **Option 2:** "I give my permission to share my substance use disorder treatment information with these specific individual(s) or organization(s)."

Name of the individual(s) and/ or healthcare organization(s) with whom I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

☐ **Option 3:** "I select both Option 1 and Option 2"

Note to receiving provider or entity: 42 CFR part 2 prohibits unauthorized disclosure of these records.

SECTION 4: Consent Expiration

I understand that my permission will end: (please select one only)

- ☐ On this date:
- ☐ One year from the date of my signature, or
- ☐ Upon my death.

I understand that I can take back or cancel my permission to share my information at any time. When I take back or cancel my permission, I understand that going forward, my information will no longer be shared.

I understand that any information that may have already been shared before I cancelled my permission cannot be taken back.

To take back or cancel your permission to share your information, please contact:

SECTION 5: Signature

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered. **I understand that I do not need to sign this form to receive care or services.**

Print the name of person giving consent or legal representative	
Signature of person giving consent or legal representative	Date (mm/dd/yyyy)

Relationship to Individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative