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King County Superior Court
BECCA Program

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH AND EDUCATION INFORMATION

Client Name: _____ Date of Birth: _____ Case Number: _____

The undersigned hereby authorizes King County BECCA programs to:

☐ Disclose information to:	☒ Obtain information from:	☒ Exchange information with:
☒ _____	Mental Health Provider	☐ Juvenile Justice Assessment Team
☐ _____	Chemical Dependency Provider	☐ _____
☒ _____	School District	☐ _____

Purpose of Release:

☐ To provide for client's current needs
☒ To help meet client's education/employment/vocational goals
☒ Coordination of care
☐ Other: Verify excuse for absence from school or exception to enrollment

Information to be disclosed: (Please check all appropriate boxes).

☒Name, date of birth, address & phone number	☐Current & past mental health treatment including assessments, dates, diagnosis & recommendations	☐Current or past out-of-home placements and related service planning from Children's Administration
☐School location, attendance, discipline, academic records, special education assessments & special education plans	☐Juvenile justice including charges, court dates, court documents and probation, at-risk-youth, or truancy requirements.	☐ Other: Information regarding youth's ability or inability to attend school on a daily basis
☐Current & past substance use treatment including assessments, dates, urinalysis, diagnosis & recommendations	☒Current & past medical treatment including dates, diagnosis & recommendations	☐ Other: JJAT Mental Health Assessment Summary JJAT SUD Assessment Summary

Disclosure/Exchange of Information: Disclosure or exchange of information shall be made to the King County BECCA Program, its employees, volunteers and/or representatives (hereafter "BECCA Program"). In this regard, I waive any physician/patient, psychologist/patient, or nurse/patient privilege in favor of the BECCA Program. Any future disclosure or exchange may be in writing or in oral conversations at the option of the BECCA Program representative. Your full cooperation with the BECCA Program is requested and appreciated. The information to be disclosed includes all health care information or other information and records requested by the BECCA Program, including protected health information as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand the educational information obtained by the BECCA Program will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances.

Specific Release: I understand that some records are protected under federal confidentiality regulations and state law. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for psychiatric disorders/mental health, drug and/or alcohol use, HIV (AIDS virus), or sexually transmitted diseases. If I have been tested, diagnosed or treated for psychiatric disorders/mental health, drug and/or alcohol use, HIV (AIDS virus), or sexually transmitted diseases, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment. I specifically authorize release of psychological treatment records. I authorize release of personal health records, including reports of examinations and treatment, progress notes, WIC records, EMS medical incident reports, X-ray/pathology reports and discharge summaries.

Manner in Which Information May be Disclosed: You are hereby authorized and requested to permit the examination of records identified above, and the copying and/or reproduction of same in any manner, whether mechanical, photographic, or otherwise, as requested by the BECCA Program and/or verbal updates regarding treatment and/or discharge summaries. A copy or facsimile of this authorization form shall have the same force and effect as a signed original.

***If you are redisclosing information related to Substance Use Disorder or Treatment the information below must be included:**
42 CFR 2.32: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. **Consent of Minor (Age 13-17**): A minor's signature is required to release information concerning chemical dependency or mental health conditions (42 CFR, Part 2; WAC 388-865, 45 CFR). Rev 1-2019

For Juvenile Justice Assessment Team (JJAT) referrals only:

By my signature below, I, _____(Initial here _____) further understand that these records will be utilized and relied upon in the process of completing a mental health assessment, substance abuse assessment (GAIN), psychological evaluation or referral for psychiatric consultation and information contained in these records may be included in these assessments. JJAT will not re-release the specific records requested. I hereby authorize release of any completed assessment generated by the Juvenile Justice Assessment Team to any member of JJAT for purposes of coordinating these assessments and to the following individuals only:

Name: _Amy Andree/Karen Chapman__ Name: _____
BECCA Case Manager Child's Attorney (if one appointed)

Name: _____ Name: _____
Other Other

Assessment Recommendations only will be released to:

Name: Melody Edmiston/Jennie Tibbitts Name: _____
Becca Coordinator School District Representative

Name: _BECCA Judicial Officer___ Name: _____
Other Other

By signing this form, I understand:

- When I am asked to fill out this authorization, I am entitled to a copy by request.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2*.
- If I do not sign this authorization, it will not affect my ability to obtain health care services from the individual health care providers identified above, but my authorization is necessary for the King County BECCA program to coordinate my care and services.
- **This authorization form is effective on the date signed below and expires ninety (90) days from said date, or upon minor's age of consent. I have the right to revoke (to end) this authorization at any time except to the extent that the program has already acted in reliance upon it. To revoke this consent I must contact the BECCA staff person named above in writing. The BECCA program is not responsible for actions already taken based upon this authorization.**

Parent of minor ____ Legal Guardian ____ Personal Representative ____ Other_____
If you are signing for someone other than yourself, please indicate. Children must also sign to give permission to disclose their own confidential records if they are over the age of consent (13 for mental health and drug and alcohol services; 14 for information about HIV/AIDS or other STDs; any age for birth control and abortions; 18 for health or other records).

Date: _____ _____
Authorized Signature

_____
Name

Date: _____ _____
Authorized Signature

_____
Name

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