TRIUMPH

Authorization for Exchange of Confidential Information Form (Third Party Payers)

Client's Name:	DOB:

I authorize Triumph Treatment Services ("Triumph") to exchange (disclose and receive) my health information with the following parties for whom I have selected below:

☐ The Washington State Health Care Authority (HCA) PO Box 45534, Olympia, WA 98504 FX: 360 507-9068	☐ Great Rivers BHO 57 W. Main St, Chehalis, WA 98532 PH: 800 392-6298 FX: 844 310-1906	☐ King County BHO 401 5th Ave, Ste. 500, Seattle, WA 98104 PH: 800 790-8049 FX: 206 296-
☐ Salish BHO 614 Division St, Port Orchard, WA 98366 FX: 360 337-5721	☐ The Community Network for Behavioral Healthcare, Inc. 1627 Main St, Ste. 1100, Kansas City, MO 64108 FX: 877 777-1388	☐ Thurston-Mason BHO 612 Woodland Sq. Loop, Ste. 401, Lacey, WA 98503 PH: 800 658-4105 FX: 360 489-1435
☐ North Sound BHO 2021 E College Way, Ste. 101 Mount Vernon, WA 98273 FX: 360 899-4754	☐ Greater Columbia BHO 101 N Edison St, Kennewick, WA 99336 PH: 509 737-2475 FX: 509 783-4165	☐ Spokane County Regional BHO 312 W 8th Ave, Spokane, WA 99204 PH: 509 477-4600
☐ CHPW-MHC PO Box 269002, Plano, TX 75026-1561 PH: 800 440-1561 FX: 206 624-3168	☐ Coordinated Care FIMC 1145 Broadway, Ste. 300, Tacoma, WA 98402 PH: 877 644-4613 FX: 877 212-6105	☐ Molina MHC 19121 SE 34th St, 2nd Floor, Vancouver, WA 98683 PH: 855 322-4082 FX: 800 767-7188
☐ United Health Care PO Box 30755, Salt Lake City, UT 84130 PH: 877 542-9231 FX: 801 994-1082	☐ Wellpoint 705 5th Ave S, Ste 300, Seattle, WA 98104 PH: 800 454-3730 FX: 844 400-3463	☐ AETNA PO Box 14079, Lexington, KY 40512-4079 FX: 859 455-8650
☐ CIGNA PO Box 188004, Chattanooga, TN 37422 FX: 866 873-7279	☐ First Choice Health PO Box 12659, Seattle, WA 98111 FX: 833 277-4256	☐ Kaiser Permanente PO Box 34585, Seattle, WA 98124 FX: 877 848-6896
☐ Molina Marketplace PO Box 22612, Long Beach, CA 90801 FX: 800 767-7188	☐ Premera Blue Cross PO Box 327, Seattle, WA 98111-0327 FX: 800 843-1114	☐ Premera Blue Cross PO Box 91059, Seattle, WA 98111-9159 FX: 425 918-5592
☐ Regence Blue Shield PO Box 30271, Salt Lake City, UT 84130-0271 FX: 888 496-1540	☐ UMR PO Box 30541, Salt Lake City, UT 84130-0541 FX: 888 742-4179	☐ Other:

This information exchange is for the purpose of coordination of care, claims payment, and healthcare operations.

This release applies to the following types of records (check all items that apply):

Substance Use Disorder Treatment Records:

- ☐ All Substance Use Disorder Records (or specify below)
  - ☐ Assessment Results/Recommendations
  - ☐ Treatment Plans
  - ☐ Lab/UA Results
  - ☐ Presence and Attendance
  - ☐ Diagnosis
  - ☐ Progress Notes
  - ☐ Discharge Summary
  - ☐ Current Medications
  - ☐ Other: Demographics

Mental Health Treatment Records:

- ☐ All Mental Health Records (or specify below)
  - ☐ Treatment Plans
  - ☐ Lab/UA Results
  - ☐ Presence and Attendance
  - ☐ Diagnosis
  - ☐ Progress Notes
  - ☐ Discharge Summary
  - ☐ Current Medications
  - ☐ Other: Demographics

I understand that my records may be protected under federal regulations governing confidentiality of alcohol and drug abuse client records, 42 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 under applicable law. By my signature below, I understand and agree that the information that will be exchanged under this Authorization may include information about my diagnosis, testing, and/or treatments for sexually transmitted diseases, mental health services, and drug and/or alcohol services. I also understand Triumph may not condition the provision of treatment on my signing of this Authorization, except for disclosures for treatment, payment, or health care operations, or health care services that are solely for the purpose of creating health information for disclosure to a third party. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

This Authorization will expire one (1) year from the date signed. **By signing below, I acknowledge that I have read and agree to the terms on both sides of this form.**

Print Client Name:	Date:
Client Signature:	

*Parent or Guardian signature required if client is under the age of 13 years old.

Print Name:	Relationship to Client:	Date:
Signature (if applicable):		