Washington State Department of Social & Health Services
Transforming lives

BEHAVIORAL HEALTH ADMINISTRATION (BHA)

BHA Personal Information Release

I, (print name) _____, give the Behavioral Health Administration (BHA) permission to use my photo, video, and/or personal information about my clinical record with BHA for marketing or public relations purposes. Information I authorize to be published may include (initial individual choices):

_____ Information about my mental health and recovery
_____ My location
_____ My name
_____ Types of services received from / coordinated by BHA
_____ My employer
_____ Other identifying information (e.g., school attended, community resources used, etc.)

Please note: If your client records include any of the following information, you must also complete this section to include these records:

I give my permission to disclose the following records (initial if applicable):

_____ Mental health
_____ Chemical dependence services / records*

<u>Notice to Recipients of Information</u>: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.

* If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2), which prohibits unauthorized disclosure of these (SUD) records. A general authorization for the release of medial or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This information may be used by BHA for (check the applicable box(es)):

☐ BHA Annual Report (including printed and online formats) BHA marketing and publications
☐ BHA public website and social media
☐ Only the specific purpose of:

Other comments:

I give my consent with no claim for a payment. I attest that I understand I am not required to agree to provide this consent, nor am I required to participate in activities for the purposes of BHA's marking and public relations, and I do so willingly and voluntarily. I understand that continued BHA services are not contingent upon signing this consent.

Signature Date	Guardian Signature (attach court order) Date
Telephone Number	If Guardian, please print name

This authorization expires two years from the date of signature, unless otherwise noted in the comments section above. Publications and materials created during this timeframe will continue to be distributed after the expiration of this release form.