Highlands Behavioral Health System
Authorization to Use or Disclose Protected Health Information

Patient Name	Date of Birth
Address (Street, City, State, Zip Code)	Phone

Release To/From:
Highlands Behavioral Health System
8565 South Poplar Way
Littleton, CO 80130

☐**To:** ☐**From:** _____ Relation_____
Address_____
Phone _____ Fax _____

Treatment Dates
- ☐ All Admissions This Facility
- ☐ This Admission Only
- ☐ Treatment Dates from

_____ to _____

Purpose of Disclosure
- ☐Continuity of Care ☐Legal ☐Personal
- ☐Summary of Treatment & Progress
- ☐Insurance ☐Disability ☐DC Planning
- ☐Coordination of Care ☐Progress During Treatment
- ☐Facilitation of Treatment, Progress, & Support
- ☐Other_____

The following Information is to be Disclosed

☐Verbal Exchange Only ☐Release of the Entire Medical record for the treatment Dates Listed Above

☐Notification of Admission	☐Notification of Discharge		
☐Discharge Plan	☐Discharge Summary	☐Psychiatric Evaluation	☐Medical History & Physical
☐Psychosocial	☐Comprehensive Assessment	☐Physician Orders	☐Physician Progress Notes
☐MARS	☐Labs	☐Radiology	☐EKG
☐Medication Reconciliation	☐Other _____		

Documents to be restricted from disclosure: _____

Redisclosure: I understand that if the requestor or receiver is not a health care provider or health care plan the released information may no longer be protected by federal privacy regulations and may be redisclosed. However, the recipient may be prohibited from disclosing substance abuse information under the Substance Abuse Confidentiality Requirements.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to: HIM Manager Highlands Behavioral Health System 8565 S. Poplar Way, Littleton, CO 80130. If I revoke this Authorization, it will not have any affect on actions taken prior to receiving the revocation.

Other Rights: I understand that:
1. My signature on this form is strictly voluntary & I may refuse to sign this Authorization
2. My treatment, payment, enrollment or eligibility for health care benefits may not be conditioned on signing this Authorization except as follows: (a) the provision of research related treatment may be conditioned on obtaining an Authorization for the use and disclosure of protected health information for research that includes treatment; and (b) the provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a 3rd party may be conditioned on obtaining an Authorization for disclosure of protected health information to such 3rd party (e.g. employment drug testing). Otherwise, my refusal to sign this Authorization will have the following consequence: This information will not be disclosed.
3. I understand that I may see & obtain a copy of the information described in this form, for a reasonable fee if I ask for it.

Expiration: Unless previously revoked, this Authorization expires in **sixty(60)** days from the date of signature.

Other Conditions: A copy or facsimile of this Authorization signed by me, may be used as if it were an original.

ACKNOWLEDGEMENT: *I request & authorize the above-named organization or individual to release the information specified above to the organization or individual named on this request.* **I ACKNOWLEDGE AND HEREBY CONSENT THAT THE RELEASED INFORMATION MAY CONTAIN INFORMATION REGARDING THE FOLLOWING CONDITIONS: SICKLE CELL ANEMIA, GENETIC TESTING, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), HUMAN INNUNODEFICIENCY VIRUS (HIV)INCLUDING TESTING OR RESULTS, DRUG ABUSE OR DEPENDENCY, ALCOHOL ABUSE OR DEPENDENCY, AND PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS _____ (Initial)**

Signature: My signature is required to validate this Authorization.

_____ _____
Patient Signature **Date** **Parent/Guardian Signature, if under age 15** **Date**

_____ _____ _____
Witness Signature (If age 15-18, witness by non-family member is required) **Witness Relation to patient** **Date/Time**

Copy of ROI given: □ Yes □ Pt Declined Date/Time:_____/_____ Staff Initials:
Print HBHS Staff Name: