Effective date: _____ Client DOB: _____ CID#_____

Please check one: Send Information Now_____ Request Information Now_____ File for Future/As Needed Use_____ One time release only_____

MENTAL HEALTH PARTNERS

1333 Iris Avenue, Boulder, CO 80304-2296 Phone 303-247-8791 FAX 303-484-4485 (Clinical Records)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:_____ Client's Date of Birth: _____

(Include client's AKA, maiden name, etc. of person receiving services at MHP)

I authorize that information may be exchanged between the following named individual or entity and Mental Health Partners (MHP):

*Name: _____ Relationship to Client: _____

Address/e-mail: _____ Phone: _____

_____ FAX: _____

☐ *Check here if this is for your Primary Care Physician*

☐ *Check here if you want to authorize release of your substance use disorder treatment information to all your past, present and future treatment providers as a general designation authorization*

***If using this form to release your SUBSTANCE USE DISORDER TREATMENT information to anyone who is NOT 1) providing treatment, or 2) paying for treatment you must indicate a specific individual (not an agency or entity) to receive that information by their first and last name.**

The purpose of the disclosure is: (It is required to check one of the purposes below or provide a specific purpose)

_____ Client requested letter _____ Coordination of care _____ Communicate about therapy results and/or attendance

_____ Obtain/maintain housing _____ Obtain/maintain benefits _____ Obtain/maintain employment/supported employment

Other (Please Specify): _____

_____

_____

Please check any items below to release the following information:

_____ **All my physical and mental health treatment records, Including HIV/AIDS (unless restricted below)

_____ **All my substance use disorder treatment (drug and alcohol) records (this can be restricted below)

_____ Diagnosis

_____ Medications

_____ Progress Notes

_____ Treatment Plan(s)

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Emergency Services Reports (§ 27-82 commitments)

_____ Psychiatric Progress Notes

_____ Employment

_____ Benefits

_____ **HIV/AIDS

_____ **Drug and Alcohol Evaluations

_____ Physical Examination

_____ Information provided by client to receive benefits

_____ Service Attendance Dates

_____ Lab Reports

_____ Patient Assistance Program (PAP) Information

_____ Intake/Admission Information

_____ Information needed to complete application for organization

_____ Discharge Summary

_____ Housing

_____ Education

Effective date: _____ Client DOB: _____ CID#_____

_____ Demographics

_____ Other (Please Specify additional items to release) _____

_____

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, reatment for alcohol and drug abuse (*protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions, and any other information in /our medical record **unless restricted as follows**: _____

_____

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to evoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to he MHP Privacy Officer or his/her designee. If not revoked earlier, this release/authorization will expire **two years** from the most recent date signed. I hereby elease the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same ffectiveness as an original. I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at MHP.

MHP does not recommend electronic format (such as e-mail, texting with clinical staff) as a means of communication with MHP employees. There s some risk that any protected health information that may be contained in such e-mail or text may be disclosed to, or intercepted by, unauthorized third arties. By signing this form, you are acknowledging that electronic media is not secure and you are releasing MHP from any liability relating to unauthorized lisclosure of PHI contained in electronic media correspondence. Charges for copies may apply: $16.50 for up to 10 pages; $.75 for pages 11-40; $.50 for each dditional page; $10 for electronic format.

Optional) I restrict the dates for which my records which can be released to between: ___/___/_____ and ___/___/_____.

_____ _____

Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including your authority to act for client

Date of Signature

_____ _____

Signature and Date to Extend Request

Signature and Date to Extend Request

_____ _____

Signature and Date to Extend Request

Signature and Date to Revoke Authorization

**NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION: This information has been disclosed to you from ecords protected by Federal Law (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further lisclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization or the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate r prosecute any alcohol or drug abuse patient.

Rev. 11/15 vr