

Today's Date: _____

I hereby authorize	<input type="checkbox"/> To provide to: <input type="checkbox"/> To receive from:
Facility Name and Address Johnstown Heights Behavioral Health 4770 Larimer Pkwy Johnstown, CO 80534	<input type="checkbox"/> Facility <input type="checkbox"/> Individual Facility Name/Name: _____ Phone: _____ Relationship: _____ Address: _____ City/State/Zip: _____ <p style="text-align: center;"><u>(ROI FORM IS ONLY VALID FOR ONE CONTACT, EACH FAMILY MEMBER OR AGENCY NEED A SEPARATE ROI COMPLETED)</u></p>

Information to be disclosed includes: <u>(please write your initials besides each category you would like released)</u>		
<input type="checkbox"/> Treatment Progress <input type="checkbox"/> History/Physical <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Diagnostic Reports <input type="checkbox"/> Psychosocial	<input type="checkbox"/> Physician Orders <input type="checkbox"/> Progress Notes <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Complete Clinical Record	<input type="checkbox"/> Financial <input type="checkbox"/> All the above <input type="checkbox"/> Other (please specify) Specify _____

Purpose(s) for the Use and/or Disclosure. The purpose(s) for the use and/or disclosure of my Protected Health Information are;
 Continuing Treatment Legal Request Family Employment Other (specify) _____

Signature of Client	Date/Time	Signature of Witness	Date/Time
		(If age 15-18, witness by non-family is required)	
Signature of Guardian or Authorized Representative	Date/Time		

Date or condition to which this consent is set to expire: _____

I, the above signature, understand that my treatment records are protected under the Federal regulations governing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, 42 USC 1320d, and Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance of it and that this consent will expire in one (1) year unless specified differently. The information on this Consent Form must be filled out completely and accurately, Federal regulations require that this form is an ORIGINAL, or release of records will be denied.

Acknowledgement: I request and authorize the above-named organizations 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 Immunodeficiency Virus (HIV), including testing or results, Drug Abuse or Dependency, Alcohol Abuse or Dependency, and Psychological or Psychiatric Conditions.

To Rescind:

I, _____ hereby rescind consent for Johnstown Heights Behavioral Health to release medical information regarding my care and treatment as provided in this Authorization for _____.

Signature of Client	Date/Time	Signature of Witness	Date/Time
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