Release of Information	[PT. STICKER/NAME/DOB]

Today's Date:_____

I hereby authorize	☐To provide to: ☐To receive from:
Facility Name and Address Johnstown Heights Behavioral Health 4770 Larimer Pkwy Johnstown, CO 80534	☐Facility ☐Individual Facility Name/Name:_____ Phone:_____ Relationship:_____ Address:_____ City/State/Zip:_____ **(ROI FORM IS ONLY VALID FOR ONE CONTACT, EACH FAMILY MEMBER OR AGENCY NEED A SEPARATE ROI COMPLETED)**

Information to be disclosed includes:	**(please write your initials beside each category you would like released)**	
_____ Treatment Progress	_____Physician Orders	_____Financial
_____ History/Physical	_____ Progress Notes	_____ All the above
_____ Psychiatric Evaluation	_____ Medication Sheets	_____ Other (please specify)
_____ Diagnostic Reports	_____ Discharge Summary	
_____ Psychosocial	_____ Complete Clinical Record	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 of1996 ("HIPAA"), 45 C.P.R. pts 160 & 164, 42 USC 1320d, and Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part2. 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. Part2, 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 herby 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.

Please see reverse to revoke ROI

***To Withdraw Authorization*:**

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