	Release of Information	Patient Label

Patient Name: _____ 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:_____Phone:_____ Name:_____Relationship:_____ Address:_____ City/State/Zip:_____

Information to be disclosed includes: (initial all information to be released)

_____ Treatment Progress _____ History/Physical _____ Psychiatric Evaluation _____ Diagnostic Reports _____ Psychosocial _____Physician Orders _____ Progress Notes	_____ Medication Sheets _____ Discharge Summary _____ Complete Clinical Record _____Financial _____ All the Above _____ Other Specify_____	**Substance Use Disorder Record Disclosure:** _____ All Substance Use Disorder Information _____ Medications and Dosages _____ Lab Results _____ Substance Use History Summaries _____Discharge Summary _____Other/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 __School __Other (specify) _____

Format of Release: ☐ Verbally, ☐ Paper Format, ☐ Electronically

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date
(If age 15-18, witness by non-family is required)

_____ _____
Signature of Guardian or Date
Authorized Representative

Consent will expire within one (1) year, unless specified differently.
Date, event, 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.

To Rescind:

I, _____ hereby rescind consent for this facility to release medical information regarding my care and treatment as provided in this Authorization for _____

_____ _____ _____ _____
Signature of Client Date Signature of Witness Date

☐ Check if patient was offered the above release form but was unable or refused to initial or sign. Staff member MUST sign signature line above.