



signature line above.

## **Release of Information**

History/Physical Psychiatric Evaluation Complete Clinical Record Information Diagnostic Reports Financial Medications and Dosages Psychosocial All the Above Lab Results Physician Orders Other Oscillary Progress Notes Progress Notes Specify 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) Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited verbally, in paper format or electronically.  Signature of Witness (If age 15-18, witness by non-family is required)  Signature of Guardian or 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 Acc Act of 1996 ("HiPAN"), 45 C, PR, pts 169 & 164, 42 USC 1320d, and Confidentiality of slobstance Use Disorder Patient Records, 42 C, FR. PR72. Understand that information specified above will be disclosed prosumation that identifies are as a patient in an aid-only on the ridge protect the confidentiality of Information and It rita be protected by the HPA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C, FR. PR72. Understand that the consent in writing at any time except to the extent that action has been taken in relative of ridge protect the confidentiality of Information that Identifies m	Patient Name:		Today's Date:	
Johnstown Heights Behavioral Health 4770 Larimer Pkwy Johnstown, CO 80534  Address:   City/State/Zip:   Relationship:   Relationship:				
Name:	Facility Name and Address	□Facility	□ Facility □ Individual	
Information to be disclosed includes:    Interaction   Treatment Progress   Medication Sheets   Substance Use Disorder Record Disclosure   History/Physical   Discharge Summary   Discharge Summary   All Substance Use Disorder Information   Diagnostic Reports   Financial   Lab Results   Lab Result	4770 Larimer Pkwy	Name:	Relationship:	
Treatment Progress				
Purpose(s) for the Use and/or Disclosure. The purpose(s) for the use and/or disclosure of my Protected Health Information areContinuing TreatmentLegal RequestFamilyEmploymentSchoolOther (specify)	Treatment Progress History/Physical Psychiatric Evaluation Diagnostic Reports Psychosocial Physician Orders	Medication Sheets Discharge Summary Complete Clinical Record Financial All the Above Other	Substance Use Disorder Record Disclosure: All Substance Use Disorder InformationMedications and DosagesLab ResultsSubstance Use History SummariesDischarge Summary	
Continuing TreatmentLegal RequestFamilyEmploymentSchoolOther (specify)			Other/Specify:	
Signature of Witness  If age 15-18, witness by non-family is required)  Date  Consent will expire within one (1) year, unless specified differently.  Date, event, or condition to which this consent is set to expire:	permitted by this authorization in any manne			
Esignature of Guardian or Date  Consent will expire within one (1) year, unless specified differently.  Date, event, or condition to which this consent is set to expire:	Signature of Client	Date		
Consent will expire within one (1) year, unless specified differently.  Date, event, or condition to which this consent is set to expire:  In the above signature, understand that my treatment records are protected under the Federal regulations governing the Health Insurance Portability and Accompact of ("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 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 be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part2. I understand that information by the HIPAA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part2. Inderstand that information by the HIPAA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part2. Inderstand that information will be decorded by the HIPAA privacy law. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part2. Inderstand that information that rediscount information that items and all patients are all patients. The Information of the drug program from re-disclosure. I understand revoke this consent inwriting 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 unles differently. The information on this Consent Form must be filled out completely and accurately, Federal regulations require that this form is an ORIGINAL, or 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 to release the information regarding the following conditions: Sickle Cell Anem Eesting, Ac	<del>-</del>			
Date, event, or condition to which this consent is set to expire:  It, the above signature, understand that my treatment records are protected under the Federal regulations governing the Health Insurance Portability and Acc Act of 1996 ("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 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 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 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 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 differently. The information on this Consent Form must be filled out completely and accurately, Federal regulations require that this form is an ORIGINAL, or 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 individuant in the released information may contain information regarding the following conditions: Sickle Cell Anem Testing, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), including testing or results, Drug Ab use or Dependency, Alcohologopendency, and Psychological or Psychiatric Conditions.  In Provided Immunodeficiency and treatment as provided in this Authorization for	•			
Act of 1996 ("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 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 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 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 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 differently. The information on this Consent Form must be filled out completely and accurately, Federal regulations require that this form is an ORIGINAL, or 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 this request. "I acknowledge and herby consent that the released information may contain information regarding the following conditions: Sickle Cell Anem Testing, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), including testing or results, Drug Ab use or Dependency, Alcohologopendency, and Psychological or Psychiatric Conditions.  O Rescind:				
hereby rescind consent for this facility to release medical hereby regarding my care and treatment as provided in this Authorization for	Act of 1996 ("HIPAA"), 45 C.P.R. pts 160 & 164, 42 information specified above will be disclosed pursube protected by the HIPAA privacy law. The Federal will continue to protect the confidentiality of inforevoke this consent in writing at any time except tidifferently. The information on this Consent Form records will be denied.  Acknowledgement: I request and authorize the aboun this request. "I acknowledge and herby consent Testing, Acquired Immunodeficiency Syndrome (A	USC 1320d, and Confidentiality of Substance Use uant to this authorization, and that the recipient of legulations governing Confidentiality of Substan mation that identifies me as a patient in an alco to the extent that action has been taken in relian must be filled out completely and accurately, Fove-named organizations or individual to release t that the released information may contain info IDS), Human Immunodeficiency Virus (HIV), incl	e Disorder Patient Records, 42 C.F.R. Part2. I understand that myl of the information may re-disclose the information and it may no lace Use Disorder Patient Records, 42 C.F.R. Part2, noted above, how ohol or other drug program from re-disclosure. I understand that ace of it and that this consent will expire in one (1) year unless specederal regulations require that this form is an ORIGINAL, or relet the information specified above to the organization or individual normation regarding the following conditions: Sickle Cell Anemia, Grant and that the information grant the following conditions:	
hereby rescind consent for this facility to release medical nformation regarding my care and treatment as provided in this Authorization for		onarions.		
nformation regarding my care and treatment as provided in this Authorization for		harahur	assind consent for this facility to release medical	
	ntormation regarding my care and treatm	ent as provided in this Authorization fo	or	
	Signature of Client	Data Signature of M	Vitness Date	

 $\Box$  Check if patient was offered the above release form but was unable or refused to initial or sign. Staff member MUST sign