SOUTHEAST HEALTH GROUP

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name:_____ Date of Birth:_____

I request and authorize Southeast Health Group to release or request information specified below to the organization, agency or individual named on this request.

This section of the form may be used as a multi-agency release of information. I authorize Southeast Health Group to release information to and obtain information from the following agencies and/or individuals:

____Primary Physician Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Social Security Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Pharmacist Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Attorney Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Social Services Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):

____Voc Rehab Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Public Health Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____School Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Probation/Parole Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____Court Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____ DOC Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____ Nursing Home/Residential Facility Name:	☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):
____ Victim Advocate Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other: Method of Release: ☐ Written ☐ Verbal For the purpose(s) of (specify):

____ Family Member(s) Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other:
	Method of Release: ☐ Written ☐ Verbal
	For the purpose(s) of (specify):
____ Other Name:	Information to be Released: ☐ All ☐ Appointment Information ☐ Psychiatric Condition/ Mental Health Treatment ☐ Medication Information ☐ Alcohol Abuse ☐ Substance Abuse ☐ Information relating to STDs including HIV or AIDS ☐ Other:
	Method of Release: ☐ Written ☐ Verbal
	For the purpose(s) of (specify):

AUTHORIZATION:
Generally these laws prohibit a covered entity like SHG from using or disclosing PHI unless authorized by individuals, except where this prohibition would result in unnecessary interference with access to quality healthcare or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for healthcare, both of which require use and disclosure of protected health information, are essential to the effective operation of the healthcare system. In addition, certain healthcare operations – such as administrative, financial, legal, and quality improvement activities – conducted by or for healthcare providers and health plans, are essential to support treatment and payment. To avoid interfering with an individual's access to quality healthcare or the efficient payment for such healthcare, the HIPAA Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and healthcare operations activities.

I understand the following BHOs are authorized to receive and re-disclose necessary health and treatment information that includes, but is not limited to medical, mental health, and substance use disorder for the purpose of processing a claim for services: Access Behavioral Care, Colorado Health Partnerships, Foothills Behavioral Health Partners, LLC, and Northeast Behavioral Health Partnership, Signal Behavioral Health Network. I hereby release these parties from any legal responsibility which may result from furnishing the information released or requested.
Further Discloser: Information disclosed for payment and reporting may be further disclosed by the recipient to Colorado Department of Health Care Policy and Financing (HCPF) and the Office of Behavior Health (OBH).

42 C.F.R. Part 2: I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Redisclosure: I understand that information provided based on this Authorization may be re-disclosed to another party by the authorized recipient and that SHG has no control over the additional disclosure and cannot protect the information after it is released based on this Authorization.

Right to Revoke: I understand that I may revoke this Authorization at any time by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions take or disclosures made while the authorization was in effect.

Conditioning: I understand that SHG may not condition healthcare treatment, payment, enrollment or eligibility for benefits on my executing this Authorization except for research purposes, for services conducted solely to produce information for a 3rd party, or enrollment in a health plan.

Psychotherapy Notes: The Authorization is not for a use or disclosure of psychotherapy notes as defined under HIPAA. SHG does not keep separate psychotherapy notes outside of those maintained in my official record.

An Authorization may not be combined with any other document to create a compound Authorization, except for research or other authorizations.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

I understand that the associated affiliates of Southeast Health Group, including Southeast Mental Health Services, Partnership for Progress, Southeast Wellness Works, and Regional Assessment Center may have access to my Protected Health Information as an SHG client for the purpose of individual client care coordination among providers.

I understand that individuals, who are interning or training at Southeast Health Group, may have access to my Protected Health Information.

This form is valid only for a one (1) year period. Each one (1) year period, clinician and/or case managers must receive written authorization to release information to complete services as planned. This Authorization will expire one (1) year from the date of my signature.

Date of Expiration: _____

☐ I understand that I am entitled to a copy of this authorization.

OTHER CONDITIONS:
A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

_____

Client's Signature Date Witness' Signature Date

_____

Person Authorized To Sign for Client (Name & Authority) Date

CANCELLATION:
I understand that I may cancel this authorization at any time as noted in the agencies Notice of Privacy Practices, except when action has already been taken to obey it.

☐ I hereby revoke this Authorization to Disclose Information

I hereby cancel the authority of Southeast Mental Health Services to release information to:

_____

_____

Date of cancellation:_____ Client's Signature:_____ Date:_____

Notice to whom this information is given: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure 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 for 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 or prosecute any alcohol or drug abuse patient.