

Please check one: Send Information Now _____ Request Information Now _____ File for Future/As Needed Use _____ One-time release only _____

MENTAL HEALTH PARTNERS
1455 Dixon Avenue, Lafayette, CO 80026 Phone 303-247-8791 FAX 303-484-4485 (Clinical Records)
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ Client's Date of Birth: _____
(Include client's AKA, maiden name, etc. of person receiving services at MHP)

I authorize that information may be exchanged between the following named individual or entity and Mental Health Partners (MHP):

*Name: _____ Relationship to Client: _____
Address/e-mail: _____ Phone: _____
FAX: _____

- Check here if this is for your Primary Care Physician
- Check here if you want to authorize release of your substance use disorder treatment information to all your past, present and future treatment providers as a general designation authorization

***If using this form to release your SUBSTANCE USE DISORDER TREATMENT information to anyone who is NOT 1) providing treatment, or 2) paying for treatment you must indicate a specific individual (not an agency or entity) to receive that information by their first and last name.**

The purpose of the disclosure is: (It is required to check one of the purposes below or provide a specific purpose)
_____ Client requested letter _____ Coordination of care _____ Communicate about therapy results and/or attendance
_____ Obtain/maintain housing _____ Obtain/maintain benefits _____ Obtain/maintain employment/supported employment
Other (Please Specify): _____

Please check any items below to release the following information:

- _____ **All my physical and mental health treatment records, including HIV/AIDS (unless restricted below)
- _____ **All my substance use disorder treatment (drug and alcohol) records (this can be restricted below)
- _____ Diagnosis _____ **Drug and Alcohol Evaluations
- _____ Medications _____ Physical Examination
- _____ Progress Notes _____ Information provided by client to receive benefits
- _____ Treatment Plan(s) _____ Service Attendance Dates
- _____ Psychological Evaluation _____ Lab Reports
- _____ Psychiatric Evaluation _____ Patient Assistance Program (PAP) Information
- _____ Emergency Services Reports (§ 27-82 commitments) _____ Intake/Admission Information
- _____ Psychiatric Progress Notes _____ Information needed to complete application for organization
- _____ Employment _____ Discharge Summary
- _____ Benefits _____ Housing
- _____ **HIV/AIDS _____ Education
- _____ Other (Please Specify additional items to release) _____

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (*)protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions, and any other information in your medical record unless restricted as follows: _____

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to the MHP Privacy Officer or his/her designee. If not revoked earlier, this release/authorization will expire **two years** from the most recent date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as an original. I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at MHP.

MHP does not recommend electronic format (such as e-mail, texting with clinical staff) as a means of communication with MHP employees. There is some risk that any protected health information that may be contained in such e-mail or text may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, you are acknowledging that electronic media is not secure, and you are releasing MHP from any liability relating to unauthorized disclosure of PHI contained in electronic media correspondence. Charges for copies may apply: \$16.50 for up to 10 pages; \$.75 for pages 11-40; \$.50 for each additional page; \$10 for electronic format.

(Optional) I restrict this release to the following dates of service: ___/___/___ and ___/___/___.

Signature of Client, Parent/Guardian (for client under 15 years of age),
or Authorized Representative, including your authority to act for client

Date of Signature

Signature and Date to Extend Request

Signature and Date to Extend Request

Signature and Date to Extend Request

Signature and Date to Revoke Authorization

***NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION: This information has been disclosed to you from records protected by Federal Law (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.
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