THE CENTER for mental health
providing help, hope and healing

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name: _____ **Date of Birth:** _____ **Client #:** _____

Authorization for Use and Disclosure of Health Information: State and federal laws govern the confidentiality and protection of individually identifiable health information. Identifying information may be released to Rocky Mountain Health Plans (RMHP) for payment and encounter reporting purposes. Except in specific situations defined in various laws, protected health information may not be disclosed without written authorization.

Authorization for Use and Disclosure of Substance Abuse Information: 42 CFR Part 2 specifically protects information about drug and alcohol abuse patients. Except in specific situations defined in various laws, protected health information may not be disclosed without written authorization.

I hereby authorize, for myself or as a legal representative, the use and disclosure of protected health information/substance abuse information by The Center for Mental Health to following persons or entities:
□ An individual(name)_____;
□ A treating provider (name/business name) _____;
□ _____, a Health Information Exchange, and all of its participants with whom I have a treating provider relationship. If the last box is checked, I understand that I am entitled, upon request, to a list of all HIE participants to whom my information was disclosed.

The Following Types of Information May Be Disclosed:

□ Assessment, Diagnosis, and Evaluations
□ All Substance Use Disorder Information
□ HIV/AIDS Information
□ Updates and Summaries
□ Medications, and Laboratory Information
□ Service Plans
□ Dates of Service: _____
□ Other _____

The information may be disclosed for treatment, payment, health care operations, and the following purposes (check all that apply):

□ Continuity of care
□ Service planning
□ Vocational service or rehabilitation
□ At the request of the client or representative
□ Multi-agency coordination of care
□ Court or agency testimony and reports
□ Other _____
□ Other _____

Further Disclosure: 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).

Psychotherapy Notes: This authorization does not permit the disclosure of psychotherapy notes.

Other Information About This Authorization: My ability to obtain services does not depend on signing this authorization unless a court or other authorized third party has required my treatment. Copies of this form may be used in lieu of the original. The party that discloses protected health information pursuant to this authorization cannot guarantee that recipients of the information will not further disclose to another party and that the information may no longer be protected. Disclosure of substance abuse information pursuant to this authorization must be accompanied by the notice required by 42 CFR 2.32.
Revocation: This authorization may be revoked at any time, in writing. If not revoked sooner, this authorization will expire upon discharge from treatment or two (2) years from the date it was signed, which ever first occurs.

Minors: If this authorization pertains to a child under fifteen (15) years of age, The Center for Mental Health reserves the right to restrict, limit, or refuse to release the child's health information and records if the information will be used in litigation involving a determination of the best interests of the child.

Reason for Disclosure of Minor Child's Records: _____

_____	_____	_____
Client or Representative Signature	Date	Representative's Relationship to Client