

**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, to  **Send**  **Receive**  **Exchange** information with the following person or agencies.

- An individual/business (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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment, Diagnosis, and Evaluations  | <input type="checkbox"/> Progress Notes            |
| <input type="checkbox"/> All Substance Use Disorder Information  | <input type="checkbox"/> Service Plans             |
| <input type="checkbox"/> HIV/AIDS Information                    | <input type="checkbox"/> Billing Statements: _____ |
| <input type="checkbox"/> Updates and Summaries                   | <input type="checkbox"/> Dates of Service: _____   |
| <input type="checkbox"/> Medications, and Laboratory Information | <input type="checkbox"/> Other _____               |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Continuity of care                             | <input type="checkbox"/> Multi-agency coordination of care     |
| <input type="checkbox"/> Service planning                               | <input type="checkbox"/> Court or agency testimony and reports |
| <input type="checkbox"/> Vocational service or rehabilitation           | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> At the request of the client or representative | <input type="checkbox"/> 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 Behavioral Health (OBH).

**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.

I intend that this document may be signed in electronic form and that my signature to this document is provided by electronic means.

\_\_\_\_\_  
Client or Representative Signature                      Date                      Representative’s Relationship to Client