GUNNISON VALLEY HEALTH
BEHAVIORAL HEALTH

Authorization for Disclosure of Mental Health Information and Confidential Substance Abuse Treatment Records

Client Name _____ DOB_____

Authorization for use and disclosure of mental health information: State and federal laws govern the confidentiality and protection of individually identifiable health information. 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: Substance abuse treatment records maintained by the Colorado Department of Human Services are confidential and will not be released, unless otherwise provided for by the regulations,without written consent from the individual or his or her personal representative.

I,_____, authorize Gunnison Valley Health Behavioral Health to release mental health information and the substance abuse treatment information of the individual named below:

I authorize the information to be disclosed received or exchanged with the following individual(s) or organization(s). (When using a general designation, you have the right to obtain, upon request, a list of entities to whom your information has been disclosed, pursuant to the general designation.)

Name _____ Organization _____

Address _____

Phone _____ Fax _____ Email _____

Purpose of Disclosure:

Continuity of Care Personal Use Legal Other _____

All of my substance use disorder information including concurrent mental health information OR

Date(s) of Service: _____

Evaluations and assessments
Medications
Prescriber notes
Psychotherapy notes
Care plan
STI/HIV/AIDS information and records
Lab results
Discharge Summary
Billing statements
Other _____

Revocation: This authorization may be revoked at any time, in writing. If not revoked sooner, this authorization will expire upon discharge from treatment or one (1) year from the date it was signed, which ever first occurs.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

_____ _____
Signature of Patient Date

_____ _____
Signature Authorized Personal Representative (if necessary) Date

_____
If signed by a Personal Representative, please state relationship and authority to consent.
This authorization reflects the requirements of 42 C.F.R. Part 2 and HIPAA.

Notice Accompanying Disclosure

Prohibition On Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a patient in substance abuse treatment, made to you with the consent of such patient. This information will be disclosed from records protected by Federal confidentiality rules set forth in 42 CFR Part 2. The Federal rules prohibit any further disclosure of this information unless such further disclosure is expressly permitted by the written consent of the person to whom the records pertain 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 contained in these records to criminally investigate or prosecute any alcohol or drug abuse patient.